MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (8)

07384

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll

City or town near Marriottsville
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 0

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State County

City or town Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Baby Antkowiak

3. (b) Social Security Number

4. Sex indeterminate

5. Color or race W

6(a) Single, married, widowed, or divorced —

B (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 26 1940

8. AGE: Years | Months | Days | If less than one day hrs. 0 min.

9. Birthplace Marriottsville Carroll Co Md
(Town, county, and state)

10. Usual occupation —

11. Industry or business

FATHER
12. Name John S Antkowiak
13. Birthplace Maryland

MOTHER
14. Maiden name Alma C Oursler
15. Birthplace Maryland

16. Informant Mrs Herbert Oursler

Address Marriottsville Md

17. Disposed of on premises Date thereof July 26 1940
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location

18. Funeral director none

Address

19. July 31 1940 C Harry Weer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26 1940, at 8 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 , to 19 ,

and that I last saw h alive on 19 .

Immediate cause of death Premature birth at 2 months

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm E. Martin
M. D. or other

Address Randallstown Date signed 7/30/40

RECEIVED
AUG 3 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

07385

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch
Stay in hospital or inst. (yrs., or mos., or days): 6 mos., 19 days
Stay in this community (yrs., or mos., or days): Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore, Ward No.:
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 1810 Madison Avenue
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: BERTHA MAE BARBOUR

3. (b) Social Security Number: None

4. Sex: Female
5. Color or race: Colored
6. (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: William Barbour, Jr.
1810 Madison Ave. 6(c) If alive, give age: 26 years
7. Birth date of deceased (mo., day, yr.): May 2, 1914

8. AGE:

Years	Months	Days	If less than one day
26	2	23	hrs. min.

9. Birthplace: South Carolina
(Town, county, and state)
10. Usual occupation: Housework
11. Industry or business: Unknown
FATHER
12. Name: Richard Rivers
13. Birthplace: South Carolina
MOTHER
14. Maiden name: Lillly Hines
15. Birthplace: South Carolina
16. Informant: Wm. A. Ventimiglia, M. D.
Address: Henryton, Maryland.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 28 (month) (day) (year)
Cemetery or crematory: Mt Calvary
Location: Baltimore County
18. Funeral director: 638 Gilmore St
Address: S. W. Chase
19. July 25 1940 (Date rec'd by registrar) Albert R. Swankhaus Registrar
Deput Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 25, 1940 19 6:30 A.M., at M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 6 19 40, to July 25 19 40, and that I last saw her alive on July 25 19 40
Immediate cause of death: Pulmonary Tuberculosis
DURATION: June 1938
Due to: --
Due to: --
Other conditions: --
(Include pregnancy within 3 months of death)
Major findings:
Of operations: --
Of autopsy: --

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: -- Date of: --
Where did injury occur? -- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): --
Means of injury: -- Injured at work? --

23. SIGNATURE: Wm. A. Ventimiglia M. D. (M. D. or other)
Address: Henryton, Maryland Date signed: 7/25/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
AUG 8 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (41)

CERTIFICATE OF DEATH

07386

Reg. Dist. No. 42

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Carroll
City or town Westminster, Md. R. D. 2
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 69-5-29

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Westminster Md R D 2 Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Albert Jacob Bemiller

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Phillie (Maehrs) Bemiller
6(c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) Feb. 2 1871

8. AGE: Years	Months	Days	If less than one day
69	5	29	hrs. min.

9. Birthplace Carroll Co. Md.
(Town, county, and state)
10. Usual occupation Farmer
11. Industry or business Farm
FATHER 12. Name John Bemiller
13. Birthplace Germany
MOTHER 14. Maiden name Lucinda Cromer
15. Birthplace Penna.
16. Informant Carl T. Bemiller.
Address Hanover Pa.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 3 1940 (month) (day) (year)
Cemetery or crematory Cemetery (Aug. 3-1940)
Location Silver Run. Md.
18. Funeral director J. M. Little & Son
Address Littlestown Pa
19. Aug 3rd 1940 (Date rec'd by registrar) Calvin T. Bankert, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 31 1940, at 3 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from the 1939, to July 31 1940, and that I last saw h- alive on July 30 1940.

Immediate cause of death	DURATION
Diabetes mellitus	15 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE H. L. Crouse M D M. D. or other
Address Littlestown Pa Date signed Aug 1- 1940

RECEIVED
SEP 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (46-B)

07387

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:
County Carroll Co.
City or town Rural, near Westminster, Md.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 76 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State ~~Carroll~~ MD. County Carroll
City or town Rural near Westminster Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. Pleasant Valley
(If rural give LOCATION)
2(a) IF YETERAN, NAME WAR X

3. (a) FULL NAME Elizabeth Catherine Bemiller
3. (b) Social Security Number none

4. Sex female
5. Color or race white
6. (a) Single, married, widowed, or divorced widowed
6 (b) Name of husband ~~or wife~~ John E. Bemiller deceased
6(c) If alive, give age X years
7. Birth date of deceased (mo., day, yr.) Nov. 24 th. 1863

8. AGE: Years 76 Months 9 Days 5 If less than one day ___ hrs. ___ min.

9. Birthplace Meadow Branch Carroll Co. MD.
(Town, county, and state)
10. Usual occupation house wife
11. Industry or business X
FATHER
12. Name George Wolf
13. Birthplace Carroll Co. Md.
MOTHER
14. Maiden name Rebecca Petry
15. Birthplace Carroll Co. Md.
16. Informant Mrs. Wm. F. Bell
Address Westminster, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof 8 1 40 (month) (day) (year)
Cemetery or crematory Meadow Branch Cem.
Location Near, Westminster Md.
18. Funeral director J. S. Myers, Jr.
Address Westminster, Md.
19. 7/30 1940 F. Woodward
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 29 1940, at 4 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 19th 1940, to July 29 1940, and that I last saw her alive on July 29 1940.
Immediate cause of death Cancer of Stomach
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. Mark Stewart M. D. or other
Address Westminster Md. Date signed July 30

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
AUG 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH tw

2411 N. Charles St., Baltimore (2)

07388

CERTIFICATE OF DEATH

Reg. Dist. No. 80.

1. PLACE OF DEATH:

County Carroll

City or town New Windsor

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) ~~[illegible]~~

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Prince George

City or town Mt Rainier Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 3629 34th St -

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR No.

3. (a) FULL NAME Foetus Bond

3. (b) Social Security Number

4. Sex ? 5. Color or race W 6.(a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 22 - 40

8. AGE: Years Months Days If less than one day

Still born hrs. min.

9. Birthplace Carroll Co Md

(Town, county, and state)

10. Usual occupation —

11. Industry or business —

FATHER 12. Name Kenneth D Bond

13. Birthplace Westminster Md

MOTHER 14. Maiden name Rosalie E. Wolf

15. Birthplace Baltimore Md

16. Informant R. E. Wolf

Address 3629 - 34th St - Mt. Rainier Md

17. Burial Date thereof July 22 40

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Westminster Cemetery

Location Westminster Md

18. Funeral director D D Hartzler & Sons

Address New Windsor Md

19 July 22 1940 Eva J Budd Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 22 1940, at 2 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from — 19 —, to — 19 —, and that I last saw h alive on — 19 —.

Immediate cause of death Still born

Intrauterine Asphyxiation

Due to

Due to

Other conditions —

(Include pregnancy within 3 months of death)

Major findings:

Of operations None

Of autopsy None

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide — Date of —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work?

23. SIGNATURE Jas. T. Marsh M.D.

M. D. or other

Address New Windsor Md Date signed 7/22/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
AUG 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B)

07389

CERTIFICATE OF DEATH

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

(S)

VS A15

1. PLACE OF DEATH:

County: Carr oll

City or town: Uniontown

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Carroll

City or town: Uniontown Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME

Brown

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
?	W	Single

6 (b) Name of husband or wife: None

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 21-1940

8. AGE: Years	Months	Days	If less than one day
0	0	0	0 hrs. 0 min.

9. Birthplace: Uniontown (Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER

12. Name: Frank Brown

13. Birthplace: Carroll Co

MOTHER

14. Maiden name: Marg Elix Stultz

15. Birthplace: Carroll Co

16. Informant: Margaret Eliz Brown

Address: Uniontown Md

17. (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory

Location: Garden of premises

18. Funeral director: Father

Address: Union town

19. 7-22-40 (Date rec'd by registrar) Margaret R. Englar Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Still Born 7-21-1940, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19, to 19,

and that I last saw h elive on 19.

Immediate cause of death	DURATION
Still born	
Due to 2 mos	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: J. H Legg M D

M. D. or other

Address: Union Bridge Date signed: 7-21-40

RECEIVED
AUG 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-C)

CERTIFICATE OF DEATH

07390
74
Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch
Stay in hospital or inst. (yrs., or mos., or days): 3 months, 6 days
Stay in this community (yrs., or mos., or days): Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 1414 Druid Hill Avenue
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: ~~Poal Bryant~~

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6 (b) Name of husband or wife: Julius Bryant
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 9, 1903

8. AGE: Years	Months	Days	If less than one day
36	6	12	hrs. min.

9. Birthplace: Matthews County, Virginia (Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business: Unknown

FATHER
12. Name: Charless Patterson
13. Birthplace: Matthews County, Virginia

MOTHER
14. Maiden name: Peggy White
15. Birthplace: Matthews County, Virginia

16. Informant: Reuben Hoffman, M. D.
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-24-40 (month) (day) (year)
Cemetery or crematory: Mt. Auburn Cem
Location: Balto. Md.
18. Funeral director: Mrs Ger. A. Holland
Address: 1631 Druid Hill Ave

19. July 21 (Date rec'd by registrar) 19 40 Albert R. Swankhaus Registrar
Deputy Local

MEDICAL CERTIFICATION 12:15 P.M.

20. DATE OF DEATH: July 21, 1940 19 , at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 15, 19 40 to July 21 19 40
and that I last saw her alive on July 21 19 40

Immediate cause of death: Pulmonary Tuberculosis — DURATION: Jan. 1940
Due to: --
Due to: --
Other conditions: --
(Include pregnancy within 3 months of death)

Major findings:
Of operations: --
Of autopsy: --

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: -- Date of: --
Where did injury occur? -- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): --
Means of injury: -- Injured at work? --

23. SIGNATURE: Reuben Hoffman, M. D.
Superintendent M. D. or other
Address: Henryton, Maryland Date signed 7/21/40

RECEIVED
AUG 3 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

107

07391

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15

1. PLACE OF DEATH:
County: Carroll.
City or town: Sykesville, Md.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Springfield State Hospital.
Stay in hospital or inst. (yrs., or mos., or days): 2 mos., 12 days.
Stay in this community (yrs., or mos., or days): Same.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland. County:
City or town: Baltimore, Ward No.:
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 939 North Washington.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Clarence Buchheister.

3. (b) Social Security Number:

4. Sex: Male.

5. Color or race: White.

6. (a) Single, married, widowed, or divorced: Married.

6 (b) Name of ~~husband or~~ wife: Estella Vancura Buchheister.

6(c) If alive, give age: Unk. years

7. Birth date of deceased (mo., day, yr.): December 13, 1902.

8. AGE: Years: 37. Months: 7. Days: 15. If less than one day: ____ hrs. ____ min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: Street-car conductor.

11. Industry or business: Baltimore Transit Co.,

FATHER
12. Name: Jacob Buchheister.
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden name: Anna Simon.
15. Birthplace: Germany.

16. Informant: Springfield Hospital Record.
Address: Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 1-40 (month) (day) (year)
Cemetery or crematory: Holy Redeemer
Location:

18. Funeral director: Leonard J. Rauch
Address: 5305 Harford Rd.

19. July 29 1940 (Date rec'd by registrar) C. Harry Weis Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 29, 1940., at 10:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1, 1940 to July 29, 1940, and that I last saw him alive on July 29, 1940.

Immediate cause of death: Acute Broncho-Pneumonia. — DURATION: 7-22-40.
Due to:
Due to:
Other conditions: Post-Encephalitis-Parkinson's Syndrome prior to 5-16-40.
(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Harry F. Baer, M.D.,
M. D. or other
Address: Sykesville, Md. Date signed: 7-29-40.

RECEIVED
AUG 3 1940
BUREAU V. S.

07392

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13E)

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 21 years, 19 days
Hospital, institution, or street address where death occurred: Springfield State Hospital
How long in hospital or institution? 21 years, 19 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2429 Edmonson Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Anthony W. Budeke

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Separated

6.(b) Name of husband or wife: Not known
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): September 2, 1884

8. AGE: Years	Months	Days	If less than one day
55	10	22	..... hrs. ..... min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: Various
FATHER 12. Name: George H. Budeke
13. Birthplace: South Carolina
MOTHER 14. Maiden name: Julia Wohl
15. Birthplace: Baltimore City
16. Informant: Records of Springfield State Hospital, Sykesville, Md.
Address
17. Burial (Burial, cremation, or removal. Which?) Date thereof July 25 1940 (month) (day) (year)
Cemetery or crematory: Loudon Park
Location
18. Funeral director: H. Sander & Son
Address: 1649 E. North Ave.
19. July 23 1940 (Date rec'd by registrar) C. Harry Hear Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 23, 1940, at 12:45 p.m.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 4, 1919 to July 23 1940 and that I last saw him alive on July 23 1940

Immediate cause of death	DURATION
Bilateral Pulmonary Tuberculosis	Reported July, 1940.
Due to	
Due to	
Other conditions: Bilateral direct inguinal hernia	10 yrs.

(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide ..... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Alan Jacobsen M. D. or other
Address: Sykesville Md. Date signed 7-23-40

VS A15 MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
AUG 3 1940
BUREAU V. S.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and forcibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07393

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1024 North Bentalou Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: William Cooper Cain

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 26, 1876

8. AGE: Years	Months	Days	If less than one day
63	10	5	hrs. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual occupation: Clerk (retired)
11. Industry or business: Armstrong Cator Corporation
FATHER 12. Name: William Francis Cain
13. Birthplace: U. S. Baltimore Md
MOTHER 14. Maiden name: Annie Elizabeth Glass
15. Birthplace: U. S. Md
18. Informant: Springfield State Hospital
Address: Sykesville, Md.
17. (Burial, cremation, or removal. Which?) Burial Date thereof (month) (day) (year) Aug 3 1940
Cemetery or crematory: Loudon Park
Location: Frederick Ave Balto Md
18. Funeral director: Wm J Tretter & Sons
Address: North Penna Ave
19. (Date rec'd by registrar) July 31 1940 C. Harry Rees Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 31 1940 at 9:30 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 23 1940 to July 31 1940 and that I last saw him alive on July 31 1940

Immediate cause of death	DURATION
Pellagra	?
Due to: Pulmonary Tuberculosis	?
Due to:	
Due to:	
Other conditions: Arteriosclerosis	?

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Lewis Danziger M. D. M. D. or other
Address: Sykesville Md. Date signed: 7-31-40

RECEIVED
AUG 2 1940
BUREAU V. S.

07394

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 17 days

Hospital, institution, or street address where death occurred: Springfield State Hosp.

How long in hospital or institution? 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: —

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 4700 Harford Ave. (If rural, give LOCATION)

2.(a) If veteran, name war: —

3. (a) FULL NAME: Dr. Frances Carpenter

3. (b) Social Security Number:

4. Sex: Female W

5. Color or race: W

6.(a) Single, married, widowed, or divorced: S

6.(b) Name of husband or wife: —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years: 82 | Months: | Days: | If less than one day ..... hrs. ..... min.

9. Birthplace: Canada (Town, county, and state)

10. Usual occupation: Physician

11. Industry or business

FATHER: 12. Name: ?

13. Birthplace

MOTHER: 14. Maiden name: ?

15. Birthplace

16. Informant: Springfield State Hospital

Address

17. Cremation (Burial, cremation, or removal. Which?) Date thereof: July 30 1940 (month) (day) (year)

Cemetery or crematory: Fort Lincoln Wash. D.C.

Location

18. Funeral director: Frederick A. Cole

Address: 1200 W Lombard St Balto Md.

19. July 29 1940 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 29 1940 at 8:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 12 1940 to July 29 1940 and that I last saw her alive on July 29 1940

Immediate cause of death	DURATION
Cardiac failure	1 mo.
Due to Arteriosclerotic heart disease	1 yr.
Due to	
Other conditions Psychosis with cerebral arteriosclerosis (Include pregnancy within 3 months of death)	1 mo.

Major findings of operations: —

Date of op.

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Jerome Hart M.D. M.D. or other

Address: Springfield State Hosp. Date signed: 7/29/40

VS A15 (T) (I) (M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUL 31 1940
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (136)

07395

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton,
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch

Stay in hospital or inst. (yrs., or mos., or days): 3 months, 9 days

Stay in this community (yrs., or mos., or days): Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore Ward No.:
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 810 W. Saratoga St.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: VERA CARTER (TORENCE)

3. (b) Social Security Number: None

4. Sex: Female

5. Color or race: Colored

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Edward Carter

6 (c) If alive, give age: Unknown years

7. Birth date of deceased (mo., day, yr.): April 14, 1919

8. AGE: Years: 21 Months: 3 Days: 3 If less than one day: ___ hrs. ___ min.

9. Birthplace: Salisbury, North Carolina
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Unknown

FATHER
12. Name: Jack Torence
13. Birthplace: unknown

MOTHER
14. Maiden name: Mozella Partee
15. Birthplace: unknown

16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 21, 1940 (month) (day) (year)

Cemetery or crematory: Mt Aeolian Cemetery

Location: Balto Md

18. Funeral director: Mrs Katie K Williams

Address: 322 N. Schroeder St.

19. 7/17/40 19 (Date rec'd by registrar) Albert R. Swankhaus Registrar
Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 17, 1940 19 ___, at 1:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 8, 1940 19 ___, to July 17 19 40, and that I last saw her alive on July 17, 1940 19 ___.

Immediate cause of death: Pulmonary Tuberculosis — DURATION: Nov. 1939

Due to: --

Due to: --

Other conditions: --
(Include pregnancy within 3 months of death)

Major findings:
Of operations: --
Of autopsy: --

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: -- Date of: --
Where did injury occur? -- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): --
Means of injury: -- Injured at work? --

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other
Superintendent
Address: Henryton, Maryland Date signed: 7/17/40

RECEIVED
AUG 3 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-B)

07396

CERTIFICATE OF DEATH

Reg. Dist. No. 79

1. PLACE OF DEATH:

County Carroll

City or town Detour (rural)
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 66 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State County

City or town Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Mrs. Carrie M. Clabaugh

3. (b) Social Security Number none

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
F	W	Married

6 (b) Name of husband or wife Edward J. Clabaugh

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 19, 1873

8. AGE: Years	Months	Days	If less than one day
66	8	20	hrs. min.

9. Birthplace Md
(Town, county, and state)

10. Usual occupation Housework

11. Industry or business

FATHER
12. Name Reuban Wilhide
13. Birthplace Md.

MOTHER
14. Maiden name Ellen Dern
15. Birthplace Md.

16. Informant Edward J. Clabaugh
Address Detour, Md.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof July 11, 1940 (month) (day) (year)

Cemetery or crematory Keysville

Location Keysville, Md.

18. Funeral director C. O. FUSS & SON
Address Taneytown, Md.

19. July 10 1940 Mrs. Pansy M. Kiev.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 9th 1940, at 4 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 21 1940, to July 9 1940, and that I last saw her alive on July 9 1940 19

Immediate cause of death Embolism, cerebral.
Duration: one-half hour ago

Due to Acute Imflam. Rheumatism

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE T. H. Legg M.D.
M. D. or other

Address Union Bridge Date signed 7-10-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
AUG 3 1940
BUREAU V. S.

VS A15 MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

07397

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll.
City or town: Sykesville, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 yrs., 7 mos., 16 days.
Hospital, institution, or street address where death occurred: Springfield State Hospital.
How long in hospital or institution? 3 yrs., 7 mos., 16 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland. County: Frederick
City or town: Ijamsville.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Charles Henry Claggett.

3. (b) Social Security Number: #

4. Sex: Male. 5. Color or race: White. 6.(a) Single, married, widowed, or divorced: Married.

6.(b) Name of ~~husband or~~ wife: Unknown.

6.(c) If alive, give age: 71. years

7. Birth date of deceased (mo., day, yr.): July 1, 1857.

8. AGE: Years: 83. Months: 1. Days: 0. If less than one day: hrs. min.

9. Birthplace: Virginia. (Town, county, and state)

10. Usual occupation: Farmer.

11. Industry or business:

FATHER
12. Name: Isaac N. Claggett.
13. Birthplace: Virginia.

MOTHER
14. Maiden name: Sally Jeffers.
15. Birthplace: Virginia.

16. Informant: Springfield Hospital Record.
Address: Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 2-40 (month) (day) (year)
Cemetery or crematory: Methodist
Location: Hyattstown

18. Funeral director: Hilton & Burdette
Address: Hyattstown, Md.

19. July 31 1940 (Date rec'd by registrar) C. Harry Wen Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 31, 1940, at 5:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 27, 1937, to July 31, 1940, and that I last saw him alive on July 31, 1940.

Immediate cause of death: Cerebral Arteriosclerosis prior to 12-14-36.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public [illegible]
Means of injury Injured at work?

23. SIGNATURE: Harry F. Baer, M.D., M. D. or other
Address: Syke[illegible] Md. Date signed 7-31-40.

RECEIVED
AUG 3 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (108)

07398

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll.
City or town: Sykesville, Md.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Springfield State Hospital.
Stay in hospital or inst. (yrs., or mos., or days) 2 yrs., 10 mos, 3 days.
Stay in this community (yrs., or mos., or days) Same.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland. County:
City or town: Baltimore, Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 4169 Fairview Avenue.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Harry Cohen.

3. (b) Social Security Number: #

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male.	White.	Widowed.

6 (b) Name of husband or wife: Ida Goldberg.
6 (c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): 1863 (Exact date unknown.)

8. AGE:

Years	Months	Days	If less than one day
77.	Unk.	Unk.	____ hrs. ____ min.

9. Birthplace: Russia.
(Town, county, and state)
10. Usual occupation: Salesman.
11. Industry or business:
FATHER 12. Name: Samuel Cohen.
13. Birthplace: Russia.
MOTHER 14. Maiden name: Bessie Levinstein.
15. Birthplace: Russia.
16. Informant: Springfield Hospital Record.
Address: Sykesville, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof July 28 1940 (month) (day) (year)
Cemetery or crematory: Batto. Hebrew
Location: Baltimore Md.
18. Funeral director: Jay & Levin
Address: 1439 E. Baltimore St.
19. July 26 1940 C. Harry Weer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 26, 1940, at 9 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 23, 1937, to July 26, 1940, and that I last saw him alive on July 26, 1940.

Immediate cause of death	DURATION
Acute Lobar Pneumonia -	one day.
Due to Haemorrhagic Infarct	one day.
Due to	
Other conditions General Arterio - sclerosis. -	one day.

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ____ Date of ____
Where did injury occur? ____ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ____
Means of injury ____ Injured at work?

23. SIGNATURE: Harry F. Baer, M.D.
M. D. or other
Address: Sykesville, Md. Date signed 7-26-40.

RECEIVED
AUG 3 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07399

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch
Stay in hospital or inst. (yrs., or mos., or days): 2 months, 4 days
Stay in this community (yrs., or mos., or days): Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Somerset
City or town: Rehobeth Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: JAMES COLLINS

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6 (b) Name of husband or wife
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): April 12, 1925

8. AGE: Years: 15 | Months: 2 | Days: 23 | If less than one day: hrs. min.

9. Birthplace: Atlantic, Virginia (Town, county, and state)

10. Usual occupation: Scholar

11. Industry or business: Unknown

FATHER
12. Name: Burley Collins
13. Birthplace: Unknown

MOTHER
14. Maiden name: Aileen Brown
15. Birthplace: Unknown

16. Informant: Dr. Reuben Hoffman
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-7-40 (month) (day) (year)
Cemetery or crematory: Christ M.E. Cemetery
Location: near Pocomoke City, Md
18. Funeral director: John A. Bradshaw
Address: Pocomoke City Md

19. 7/5/40 19 (Date rec'd by registrar) Albert A. Swanborn Registrar
Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 5, 1940 19 , at 4:05 A.M. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1940 to July 5 1940, and that I last saw h Im alive on July 5 1940

Immediate cause of death: Pulmonary Tuberculosis — DURATION: Nov. 1939

Due to: --

Due to: --

Other conditions: --

(Include pregnancy within 3 months of death)

Major findings:
Of operations: --

Of autopsy: --

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide -- Date of --
Where did injury occur? -- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) --
Means of injury -- Injured at work? --

23. SIGNATURE: Reuben Hoffman, M. D.
Superintendent M. D. or other
Address: Henryton, Maryland
Date signed: 7/5/40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
AUG 3 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07400

13-

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 mos., 7 days

Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch

How long in hospital or institution? 5 mos., 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Wicomico

City or town: Sharptown
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

ALESIA VIRGINIA COOK

3.(b) Social Security Number

None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept. 13, 1924

8. AGE: Years	Months	Days	If less than one day
15	10	17	..... hrs. ..... min.

9. Birthplace: Sharptown, Maryland
(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business: Unkown

FATHER
12. Name: Clarence Cook
13. Birthplace: Sharptown, Maryland

MOTHER
14. Maiden name: Virgie Quinton
15. Birthplace: Sharptown, Maryland

16. Informant: Wm. A. Ventimiglia, M. D.
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 2, 1940 (month) (day) (year)

Cemetery or crematory: San Domingo Cem.

Location: Wicomico Co. Md.

18. Funeral director: J. J. Frampton
Address: Frederalsburg, Md.

19. July 30, 1940 (Date rec'd by registrar) Albert R. Swankhaus Registrar
Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 30, 1940 19..... at 3:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 23, 1940 to July 30 1940 and that I last saw her alive on July 30 1940

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Dec. 1939
Due to --	
Due to --	
Other conditions --	

(Include pregnancy within 3 months of death)

Major findings of operations --

Date of op. --

Autopsy results --

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide -- Date of --

Where did injury occur? -- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) --

Means of injury -- Injured at work? --

23. SIGNATURE: Wm. A. Ventimiglia, M. D.
M. D. or other

Address: Henryton, Maryland Date signed: 7/30/40

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

M

1

RECEIVED
AUG 3 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

13-C

07401

CERTIFICATE OF DEATH

Reg. Dist. No. 24

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Springfield State Hospital

Stay in hospital or inst. (yrs., or mos., or days): 4 mos., 29 days

Stay in this community (yrs., or mos., or days): 4 mos., 29 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Baltimore City

City or town: Baltimore Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 3121 Brendon Ave.

(If rural give LOCATION)

2(c) IF VETERAN, NAME WAR

3. (a) FULL NAME: Earle William Cooper

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Dec. 15, 1900

8. AGE:

Years	Months	Days	If less than one day
39	6	27	____ hrs. ____ min.

8. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER — 12. Name: Benjamin Cooper

13. Birthplace: ?

MOTHER — 14. Maiden name: Margaret Thompson

15. Birthplace: ?

16. Informant: Hospital records

Address: Sykesville Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 15, 1940 (month) (day) (year)

Cemetery or crematory: Morland Park Cem.

Location: Balto. Md.

18. Funeral director: G. Howard Strong

Address: Eight & Montgomery Sts

19. July 12 1940 (Date rec'd by registrar) C. Harry Feiser Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 12, 1940, at 2:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 13, 1940 to July 12, 1940, and that I last saw him alive on July 11, 1940.

	DURATION
Immediate cause of death: Pulmonary tuberculosis	2 mos.
Due to	
Due to	
Other conditions: Epilepsy	33 yrs.

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE: Joseph H. Marshall, M. D. M. D. or other

Address: Springfield State Hospital Date signed: 7-12-40

RECEIVED
JUL 17 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

CERTIFICATE OF DEATH

07402

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Carroll,
City or town Sykesville, Md.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Springfield State Hospital,
Stay in hospital or inst. (yrs., or mos., or days) 8 yrs, 1 mo, 18 days.
Stay in this community (yrs., or mos., or days) Same.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland. County #
City or town Baltimore, Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 3207 Guilford Avenue.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR #

3. (a) FULL NAME Harry M. Coster.

3. (b) Social Security Number #

4. Sex: Male.
5. Color or race: White.
6. (a) Single, married, widowed, or divorced: Single.
6 (b) Name of husband or wife
6(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) December 1, 1887.
8. AGE: Years 52 | Months 7. | Days 6. | If less than one day: hrs. min.
9. Birthplace Solomons Island, Md.
(Town, county, and state)
10. Usual occupation None.
11. Industry or business
FATHER 12. Name Thomas I. Coster,
13. Birthplace Calvert County, Md.
MOTHER 14. Maiden name Mary J. Hellen,
15. Birthplace Calvert County, Md.
16. Informant Springfield Hospital Record.
Address Sykesville, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof July 9 1940 (month) (day) (year)
Cemetery or crematory Middleham Chapel
Location Calvert Co Md.
16. Funeral director Wm. J. Baker & Sons
Address North & Penna Ave.
19. July 7 1940. C. Harvey Tolson
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 7, 1940, at 2.40 A. M.
21. I CERTIFY, that death occurred on the date above stated; that I attended deceased from Oct. 1 1938 to July 7, 1940, and that I last saw him alive on July 7, 1940.

Immediate cause of death: Cerebral Haemorrhage — DURATION 6-30-40.
Due to Idiopathic Vascular Hypertension — prior to 12-18-32.
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Harry F. Baer, M.D.
M. D. or other
Address Sykesville, Md. Date signed 7-7-40.

RECEIVED
JUL 10 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 7 — 07413

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

V8 A15

1. PLACE OF DEATH:
County Carroll
City or town Westminster
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 182 E. Green Street
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 85 10 19

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Westminster Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 182 E. Green
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Margaret E. Crass

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

6 (b) Name of husband or wife
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 12 1854

8. AGE:

Years	Months	Days	If less than one day
85	10	19	hrs. min.

9. Birthplace (Town, county, and state) Westminster Carroll Co. Md.

10. Usual occupation none

11. Industry or business

FATHER
12. Name George C. Crass
13. Birthplace Maryland

MOTHER
14. Maiden name Catherine Fleagle
15. Birthplace Maryland

16. Informant Mrs. E. J. Hill
Address 182 E. Green St. Westminster, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 3. 1940 (month) (day) (year)
Cemetery or crematory St. Johns Cem.
Location Westminster, Md.

18. Funeral director H. Bankard & Son
Address Westminster, Md.

19. 8/1 1940 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 31st 1940, at 12 30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from about July 31st 1937, to July 31st 1940, and that I last saw him alive on July 31st 1940.

	DURATION
Immediate cause of death Uremia Coma	2 days
Due to Cardiac-Renal-Vascular Chronic Nephritis	1 yr.
Due to cerebral Hemorrhage	3 yrs. ago
Due to Senility	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. L. Billingslea M. D. or other
Address Westminster, Md. Date signed 8/1/40

RECEIVED
AUG 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

07404

CERTIFICATE OF DEATH

Reg. Diat. No. 74

1. PLACE OF DEATH:

County: Cypress

City or town: Lyrecrest
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 yrs 7 da.

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 5 mo. 19 da.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1839 La Clinton St.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Sarah Deady

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	widowed

6.(b) Name of husband or wife: (Maiden name) Deady

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug. 14. 1867

8. AGE: Years	Months	Days	If less than one day
72	11	5	hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Housewife.

11. Industry or business:

FATHER
12. Name: William Devan
13. Birthplace: Wales

MOTHER
14. Maiden name: Margaret Evans
15. Birthplace: Wales

16. Informant: Hospital Records
Address: Lyrecrest, Md.

17. (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory: Mt Carmel

Location: Dromedary Rd

18. Funeral director: Samuel F. Hohmann

Address: 1639 N Broadway

19. July 19 1940 (Date rec'd by registrar) C. Harry Haer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 19 1940 at 6:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 21 1940, to July 19 1940 and that I last saw h alive on July 19 1940.

Immediate cause of death	DURATION
Arteriosclerosis	1936
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Maud M Rue M.D.
M. D. or other

Address: Lyrecrest Date signed: 7-19-40

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
JUL 31 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13E)

CERTIFICATE OF DEATH

07405

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch
Stay in hospital or inst. (yrs., or mos., or days): 1 month, 23 days
Stay in this community (yrs., or mos., or days): Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 1034 North Arlington Ave.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Alexander Dodson

3. (b) Social Security Number: 217-03-5034 (Rose)

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6 (b) Name of husband or wife: Bessie Dodson
6(c) If alive, give age: Unknown years

7. Birth date of deceased (mo., day, yr.): October ?. 1882

8. AGE: Years	Months	Days	If less than one day
57	9	?	____ hrs. ____ min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual occupation: Tending to new houses
11. Industry or business: Unknown

FATHER
12. Name: William Dodson
13. Birthplace: Unknown

MOTHER
14. Maiden name: Olivia Lee
15. Birthplace: Baltimore, Maryland

16. Informant: Dr. Reuben Hoffman
Address: Henryton, Maryland

17. (Burial, cremation, or removal. Which?) Date thereof: July 14. 1940 (month) (day) (year)
Cemetery or crematory: Mt Auburn
Location: Baltimore City
18. Funeral director: Geo. S. Kelson
Address: 1303 Presstman St.

19. 7/14/40 19____ (Date rec'd by registrar) Albert R. Swankhaus, Registrar
Deputy Local

MEDICAL CERTIFICATION 2:20 P.M.

20. DATE OF DEATH: July 14, 1940 19____, at____ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 20 19 40, to July 14 19 40, and that I last saw h im alive on July 14, 1940 19____

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Feb. 1940
Due to --	
Due to --	
Other conditions --	

(Include pregnancy within 3 months of death)

Major findings:
Of operations --
Of autopsy --

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide -- Date of --
Where did injury occur? -- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) --
Means of injury -- Injured at work? --

23. SIGNATURE: Reuben Hoffman, M.D.
Superintendent (M. D. or other)
Address: Henryton, Maryland Date signed: 7/14/40

JUL 17 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46 (B) ✓

CERTIFICATE OF DEATH

07406

Reg. Dist. No. 5-5

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Carroll
City or town near Manchester
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 55 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Rural near Manchester Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR —

3. (a) FULL NAME Emeline Doll

3. (b) Social Security Number none

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Femal	White	married

6 (b) Name of husband ~~or wife~~ Frank E Doll
6(c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) Aug. 10, 1884

8. AGE:

Years	Months	Days	If less than one day
55	11	12	____ hrs. ____ min.

9. Birthplace Penna. (Town, county, and state)
10. Usual occupation Housework
11. Industry or business
FATHER 12. Name Daniel B Kerchner
13. Birthplace Unknown
MOTHER 14. Maiden name Matilda Strasback
15. Birthplace Unknown
16. Informant Frank E Doll
Address Millers Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-24-1940 (month) (day) (year)
Cemetery or crematory cemetery
Location Manchester Md
18. Funeral director Jacob Winks Sons
Address Manchester Md
19. July 23 (Date rec'd by registrar) 1940 Mo. H. G. S. Denner Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 22 1940, at 6 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1 1940, to July 22 1940, and that I last saw h alive on July 21 1940

Immediate cause of death	DURATION
Carcinoma Stomach	6 mos
Due to Metastasis to Liver & peritoneum	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE William R B Denner M. D. or other
Address Manchester Md Date signed 7/23/40

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

074017

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch

Stay in hospital or inst. (yrs., or mos., or days): 14 days

Stay in this community (yrs., or mos., or days): 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Bethesda Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: River Road

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: ALINE MARY DORSEY

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	COLORED	MARRIED

6 (b) Name of husband or wife: James Dorsey

Bethesda, Md. 6(c) If alive, give age: 45 years

7. Birth date of deceased (mo., day, yr.): Unknown (1899)

8. AGE: Years	Months	Days	If less than one day
40	?	?	____ hrs. ____ min.

9. Birthplace: Washington, D. C. (Town, county, and state)

10. Usual occupation: Housework (domestic)

11. Industry or business: unknown

FATHER — 12. Name: Cascish Parker

FATHER — 13. Birthplace: Washington, D. C.

MOTHER — 14. Maiden name: Eliza Parker

MOTHER — 15. Birthplace: Maryland

16. Informant: Dr. Reuben Hoffman

Address: Henryton, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof July 13 1940 (month) (day) (year)

Cemetery or crematory: Lincoln Memorial

Location: Washington D. C.

18. Funeral director: Robert L. Snowden

Address: Rockville Md

19. 7/10/40 (Date rec'd by registrar) Albert R. Swanhaus Registrar

Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 10, 1940 at 4:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 26, 1940 to July 10, 1940

and that I last saw her alive on July 10, 1940

Immediate cause of death	DURATION
Pulmonary Tuberculosis	duration unknown
Due to --	
Due to --	
Other conditions --	

(Include pregnancy within 3 months of death)

Major findings: --

Of operations: --

Of autopsy: --

PHYSICIAN — Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide -- Date of --

Where did injury occur? -- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) --

Means of injury -- Injured at work? --

23. SIGNATURE: Reuben Hoffman M. D. M. D. or other

Superintendent

Address: Henryton, Maryland Date signed 7/10/40

RECEIVED
AUG 3 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (191)

CERTIFICATE OF DEATH

07408

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll.
City or town: Sykesville, Md.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Springfield State Hospital.
Stay in hospital or inst. (yrs., or mos., or days) 21 yrs, 2 mos, 18 days.
Stay in this community (yrs., or mos., or days) same.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland, County: Carroll.
City or town: Taneytown. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: John H. Eckard.

3. (b) Social Security Number: #

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male.	White.	Single.

6 (b) Name of husband or wife
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): February 16, 1865.

8. AGE:

Years	Months	Days	If less than one day
85.	5.	11.	hrs. min.

9. Birthplace: Carroll Co., Md.
(Town, county, and state)

10. Usual occupation: Farmer.

11. Industry or business

FATHER
12. Name: Uriah Eckard.
13. Birthplace: Carroll Co., Md.

MOTHER
14. Maiden name: Annie Leister
15. Birthplace: Carroll Co., Md.

18. Informant: Springfield Hospital Record.
Address: Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 30, 1940 (month) (day) (year)
Cemetery or crematory: Reformed Cem.
Location: Uniontown, Md.

18. Funeral director: C. O. Fuss & Son
Address: Taneytown, Md.

19. July 28 19 40 C. Harry Baer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 27, 1940, at 11:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 1, 1936, to July 27, 1940, and that I last saw him alive on July 27, 1940.

Immediate cause of death	DURATION
Chronic Myocarditis. Due to	1935.
General Arteriosclerosis.	Unk.
Due to	
Other conditions: Heat Exhaustion. one	day.

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: Harry F. Baer, M.D., M. D. or other
Address: Sykesville, Md. Date signed 7-27-40.

RECEIVED
AUG 3 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

07409

CERTIFICATE OF DEATH

Reg. Dist. No. 71

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Garrett
City or town: Uniontown
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 80 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: County:
City or town: Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Mrs. Susan Caroline Eckard

3. (b) Social Security Number: None

4. Sex: F
5. Color or race: W
6. (a) Single, married, widowed, or divorced: widow
6 (b) Name of husband or wife: L. F. Eckard
6(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Nov 27, 1855
8. AGE: Years: 84 Months: 7 Days: 14 If less than one day: hrs. min.
9. Birthplace: Md. (Town, county, and state)
10. Usual occupation: Housework
11. Industry or business:
FATHER 12. Name: Hezekiah Yingling
13. Birthplace: Md
MOTHER 14. Maiden name: Caroline Harbaugh
15. Birthplace: Md
16. Informant: Mrs. J. L. Derrikson
Address: Uniontown, Md
17. Burial (Burial, cremation, or removal. Which?): Date thereof: July 14, 1940 (month) (day) (year)
Cemetery or crematory: Lutheran
Location: Uniontown, Md
18. Funeral director: C. D. Susat & Son
Address: Taneytown, Md
19. July 12 1940 (Date rec'd by registrar) Margaret R. Englar Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 7-11-1940, at 6 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 3 1940, to July 11 1940, and that I last saw h alive on 7-10- 1940.

Immediate cause of death	DURATION
Cerebral hemorrhage	8 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: J. H. Legg M. D. or other
Address: Union Town, Md. Date signed 7-11-40

RECEIVED
AUG 5 1940
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07410

(92-d)

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 days

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore City (If outside city or town limits, write RURAL and give nearest town)

Street No.: 107 S. Eaton Street (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Pauline Flick

3.(b) Social Security Number:

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Widowed

6.(b) Name of husband or wife: Not known

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 25, ~~1868~~ 1870

8. AGE: Years ~~72~~ 70 | Months 0 | Days 18 | If less than one day: hrs. min.

9. Birthplace: Germany (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: ------

FATHER

12. Name: John Johnson

13. Birthplace: Germany

MOTHER

14. Maiden name: ~~Mary~~ Caroline Jensen

15. Birthplace: Germany

16. Informant: Records of Springfield State Hospital, Sykesville, Md.

Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 26/40 (month) (day) (year)

Cemetery or crematory: Cathedral Cemetery

Location: Baltimore

16. Funeral director: John Ulrich

Address: 2008 Orleans St

19. July 23 1940 (Date rec'd by registrar) O. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 23, 1940 at 11:50 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 19 1940 to July 23 1940 and that I last saw her alive on July 23 1940

Immediate cause of death: Chronic myocarditis and chronic endocarditis — DURATION: Unknown

Due to:

Due to:

Other conditions: Generalized Arteriosclerosis — ?

(Include pregnancy within 3 months of death)

Major findings of operation: Autopsy: --Ulcerative arteriosclerotic endocarditis; cardiac hypertrophy with myocardial degeneration.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Alan Jacobs M. D. or other

Address: Sykesville Md. Date signed: 7-23-40

authorization to change date of birth and mother's name
see letter filed under Jones in permanent file.

RECEIVED
AUG 3 1940
U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (164-C)

07411

CERTIFICATE OF DEATH

Reg. Dist. No. 78

1. PLACE OF DEATH:

County Carroll

City or town Rural - Mt Airy

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Cover's Corner

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) Life

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Carroll

City or town Rural Mt Airy Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. Nr Cover's Corner

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR None

3. (a) FULL NAME Aubrey Austin Fritz

3. (b) Social Security Number None

4. Sex M.

5. Color or race White

6. (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Rhoda Ellen Fritz

6(c) If alive, give age 38 years

7. Birth date of deceased (mo., day, yr.) January 29, 1900

8. AGE: Years 40 Months 5 Days 22 If less than one day ___ hrs. ___ min.

9. Birthplace Nr Mt Airy Carroll Co. Md (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name Francis David Fritz

13. Birthplace Md.

MOTHER 14. Maiden name Fanny L. Rippeon

15. Birthplace Md.

16. Informant Mrs. A. A. Fritz

Address Mt Airy Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 31, 1940 (month) (day) (year)

Cemetery or crematory Fairmount

Location Libertytown

18. Funeral director C. M. Waltz

Address Winfield Md

19. July 30 1940 (Date rec'd by registrar) E. M. Farver Local Registrar

MEDICAL CERTIFICATION after

20. DATE OF DEATH July 21 1940, at 10 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ___ 19___, to ___ 19___, and that I last saw h___ alive on ___ 19___.

Immediate cause of death Bullet Wound in Head. Self inflicted.

Due to

Due to

Other conditions ___

(Include pregnancy within 3 months of death)

Major findings: ___

Of operations

Of autopsy None

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Suicide Date of 7-21-40

Where did injury occur? Carroll (City or town) (County) Md (State)

Injured at home, farm, industry, public place (where?) Thurman Wright's Woods

Means of injury 32 Revolver Injured at work? No

23. SIGNATURE Jas. T. Marsh Deputy Medical Examiner M. D. or other

Address New Windsor Md Date signed 7-29-40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
AUG 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

07412

Reg. Dist. No. 94

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County Carroll

City or town Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs 1 mo 6 da

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 2 yrs 1 mo 6 da

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 416 East 20th St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Catherine O'Neill Gibbons

3. (b) Social Security Number

4. Sex: F. | 5. Color or race: W. | 6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: John J. Gibbons

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 24 or 1872

8. AGE: Years 68 | Months 1 | Days 22 | If less than one day ..... hrs. ..... min.

~~Space~~

9. Birthplace West Virginia (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Home

FATHER 12. Name Thomas O'Neill

13. Birthplace Ireland

MOTHER 14. Maiden name Mary Lenehan

15. Birthplace Ireland

16. Informant Hospital Record

Address Sykesville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7 (month) 24 (day) 40 (year)

Cemetery or crematory Holy Cross

Location Landover Road

18. Funeral director Chas. E. Evans Son Inc

Address 1184 W. Mt Royal Ave

19. July 21 1940 (Date rec'd by registrar) C. Harry Weis Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 21st 1940 at 5:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 20 1939 to July 21 1940 and that I last saw h.e.r. alive on July 20 1940

Immediate cause of death	DURATION
Arteriosclerosis	5 yr.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Maud M. Rees M. D.

M. D. or other

Address Sykesville Md Date signed 7-24-40

RECEIVED
JUL 23 1940
BUREAU V. S.

(M)

VS A15 (T)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07413

(13P)

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 yrs., 5 mos., 2 days

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 7 yrs., 5 mos., 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Prince George's

City or town: Capitol Heights (If outside city or town limits, write RURAL and give nearest town)

Street No.: ---- (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Elsie Dorothy Gover

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Howard P. Gover

6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): June 4, 1898

8. AGE: Years	Months	Days	If less than one day
42	1	20	..... hrs. ..... min.

9. Birthplace: Alexandria, Virginia (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: ----

FATHER
12. Name: Robert Stribling
13. Birthplace: Virginia

MOTHER
14. Maiden name: ? Hawes
15. Birthplace: Virginia

16. Informant: Records of Springfield State Hospital, Sykesville, Md.
Address:

17. Removal (Burial, cremation, or removal. Which?) Date thereof: July 25 1940 (month) (day) (year)

Cemetery or crematory:

Location: Washington, D.C.

18. Funeral director: W. W. Chambers Co.

Address: 517-11th St SE Wash D.C.

19. July 25 1940 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 24 1940 at 11:40 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 2 1933 to July 24 1940 and that I last saw her alive on July 24 1940

Immediate cause of death	DURATION
Tuberculous pneumonia	2 days
Due to Pulmonary tbc	Unk.
Due to	
Other conditions Post encephalitic Parkinsonism	13 yrs

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Lewis Danziger M.D. M. D. or other

Address: Sykesville. Md. Date signed: 7-25-40

RECEIVED
AUG 3 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-E)

CERTIFICATE OF DEATH

07414

Reg. Dist. No. 17

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Carroll
City or town Hampstead
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 15 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Hampstead Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. ~
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR ~

3. (a) FULL NAME Harvey P Greenholtz

3. (b) Social Security Number ~

4. Sex: Male | 5. Color or race: White | 6.(a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife ~

6(c) If alive, give age ~ years

7. Birth date of deceased (mo., day, yr.) January 4 1868

8. AGE: Years 72 | Months 6 | Days 10 | If less than one day ____ hrs. ____ min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Day Laborer.

11. Industry or business

FATHER
12. Name Wm. W. Greenholtz
13. Birthplace Maryland

MOTHER
14. Maiden name Margaret L Baker.
15. Birthplace Maryland

16. Informant Emory H Albaugh.
Address Hampstead Md

17. Burial Date thereof July 17 1940
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Bethel Methodist
Location Near New Windsor, Carroll Co.

18. Funeral director Edw C Lipton
Address Hampstead Md

19. July 14 1940 John S. Hughes, Jr.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 14 1940 at 7:57 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 9 1940, to July 14 1940, and that I last saw him alive on July 14 1940.

Immediate cause of death	DURATION
Cerebral Thrombosis	5 days
Due to Arterio-sclerosis	years
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE M. C. Partenfield M. D. or other
Address Hampstead Md Date signed July 14 1940

RECEIVED
AUG 2 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73-L)

CERTIFICATE OF DEATH

07415

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 days

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Baltimore City

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 528 South Caroline Street (If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Sophia Greenwald

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Not known

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): April 26, 1867

8. AGE: Years	Months	Days	If less than one day
73	2	9	..... hrs. ..... min.

8. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business:

FATHER — 12. Name: Not known

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Caroline Kane

15. Birthplace: Maryland

16. Informant: Springfield State Hospital

Address: Sykesville, Maryland

17. (Burial, cremation, or removal. Which?) Date thereof ..... (month) (day) (year)

Cemetery or crematory: Oak Lawn

Location: Balto Co

18. Funeral director: William Gieselmann

Address: 1618 Eastern Ave

19. 7-6-40 19..... Ostarry Hunn

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 5th 1940 at 11:15p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1, 1940 to July 5 1940 and that I last saw her alive on July 5, 1940

Immediate cause of death	DURATION
Cerebral thrombosis	March, 1940
Due to: Arteriosclerosis	
Due to:	
Other conditions: Chronic myocarditis	Unknown

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Lewis Danzi jr. M.D. M. D. or other

Address: Sykesville, Md Date signed: 7-6-40

RECEIVED
JUL 9 1940
BUREAU V. R.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (53)

CERTIFICATE OF DEATH

07416

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll.
City or town: Sykesville, Md.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Springfield State Hospital.
Stay in hospital or inst. (yrs., or mos., or days): 13 yrs, 8 mos, 4 days.
Stay in this community (yrs., or mos., or days): Same.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland. County:
City or town: Baltimore. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 1332 South Hanover.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: #

3. (a) FULL NAME: Joseph Grieten (Griten)

3. (b) Social Security Number: #

4. Sex: Male.

5. Color or race: White.

6. (a) Single, married, widowed, or divorced: Separated.

6 (b) Name of ~~husband or~~ wife: Unknown.

6 (c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): December 2, 1884.

8. AGE: Years: 55. Months: 6. Days: 28. If less than one day: ____ hrs. ____ min.

9. Birthplace (Town, county, and state): Baltimore, Md.

10. Usual occupation: Hotel Keeper.

11. Industry or business:

FATHER
12. Name: Frank Grieten.
13. Birthplace: Belgium.

MOTHER
14. Maiden name: Annie Hammerbacher.
15. Birthplace: Baltimore, Md.

16. Informant: Springfield Hospital Record, Sykesville, Md.
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 3 1940 (month) (day) (year)
Cemetery or crematory: Western
Location: Baltimore Md.

18. Funeral director: C. H. Kean
Address: Sykesville Md.

19. July 1 1940 C. Harry Kean
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 1, 1940, at 9:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 1, 1938 to July 1, 1940. and that I last saw him alive on July 1, 1940.

Immediate cause of death: Basal Cell Carcinoma of face and neck. — DURATION: 1926.

Due to: ____

Due to: ____

Other conditions: ____

(Include pregnancy within 3 months of death)

Major findings:
Of operations: ____
Of autopsy: ____

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ____ Date of: ____
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ____
Means of injury: ____ Injured at work?

23. SIGNATURE Harry F. Baer, M.D. M. D. or other
Address: Sykesville, Md. Date signed 7-1-40.

RECEIVED
AUG 3 1940
BUREAU V. S.

07417

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. — MARGIN RESERVED FOR BINDING — VS A15

1. PLACE OF DEATH:
County: Carroll.
City or town: Sykesville, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 29 yrs., 20 days.
Hospital, institution, or street address where death occurred:
Springfield State Hospital.
How long in hospital or institution? 29 yrs., 20 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland. County:
City or town: Baltimore,
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1933 Eastern Avenue,
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: John Grzelecki.

3.(b) Social Security Number: #

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male.	White.	Married (?).

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1878, exact date unknown.

8. AGE: Years	Months	Days	If less than one day
62.	Unk.	Unk.	hrs. min.

9. Birthplace: Poland. (Town, county, and state)
10. Usual occupation: Laborer.
11. Industry or business
FATHER 12. Name: Unknown.
13. Birthplace: Poland.
MOTHER 14. Maiden name: Unknown.
15. Birthplace: Poland.
16. Informant: Springfield Hospital Record.
Address: Sykesville, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/2/40 (month) (day) (year)
Cemetery or crematory: Holy Rosary Cem
Location: Baltimore County
18. Funeral director: John M. Weber
Address: 401 S. Chester St.
19. Aug 1 1940 (Date rec'd by registrar) Harry Steen Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 30, 1940, at 2 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 10, 1936, to July 30, 1940, and that I last saw him alive on July 30 1940.

Immediate cause of death	DURATION
Cerebral Haemorrhage	one day.
Due to	
Due to	
Other conditions: Dementia Praecox — Katatonic Type · prior to 7-10-11.	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Harry F. Baer, M.D., M. D. or other
Address: Sykesville, Md. Date signed 7-30-40.

RECEIVED
AUG 3 1940
BUREAU A. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

07418

CERTIFICATE OF DEATH

Reg. Dist. No. 81

1. PLACE OF DEATH:

County: Carroll Co

City or town: Union Bridge Md
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days): Lifetime

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State _____ County _____

City or town _____ Ward No. _____
(If outside city or town limits, write RURAL NEAR and give town)

Street No. _____
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR _____

3. (a) FULL NAME: Lydia Jane Hammond

3. (b) Social Security Number

4. Sex: Female

5. Color or race: Black

6. (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Dennis Hammond

6(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.): July 15 - 1848

8. AGE: Years 92 | Months 0 | Days 16 | If less than one day _____ hrs. _____ min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: House wife

11. Industry or business

FATHER
12. Name: Thomas Jones
13. Birthplace: Unknown

MOTHER
14. Maiden name: Rebeca Burkett
15. Birthplace: Unknown

16. Informant: Meston P. Hammond
Address: Union Bridge. Md

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: Aug 3 (month) (day) (year)

Cemetery or crematory: Fairview

Location: Carroll Co. Md

18. Funeral director: Raymond K. Wright
Address: Union Bridge. Md

19. Aug. 2 1940
(Date rec'd by registrar)
P. Eichman
Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 31, 1940, at 4 45/10 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1940, to July 31 1940, and that I last saw her alive on July 30 1940.

Immediate cause of death: Acute Cardiac Dilatation — DURATION: 1 hr

Due to: Chronic Myocarditis — 12 yrs

Due to: Generalized arteriosclerosis — 12 yrs

Other conditions: —
(Include pregnancy within 3 months of death)

Major findings:
Of operations: None
Of autopsy: None

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____
Where did injury occur? _____ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) _____
Means of injury _____ Injured at work? _____

23. SIGNATURE: Jas. T. Thorsh
M. D. ~~or other~~
Address: Needlomedsor Md
Date signed: 8/1/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
AUG 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07419

Reg. Dist. No. 71

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Carroll
City or town Uniontown Rural mail
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 18 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Uniontown Rural mail Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Fannie Crabbs Harris

3. (b) Social Security Number none

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
F	W	married

6 (b) Name of husband or wife Samuel Harris
6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) Nov. 27 1871

8. AGE: Years	Months	Days	If less than one day
68	7	19	hrs. min.

9. Birthplace Carroll Co. Maryland (Town, county, and state)
10. Usual occupation none
11. Industry or business

FATHER
12. Name Lee Poulson
13. Birthplace md.

MOTHER
14. Maiden name Rebecca Davis
15. Birthplace md.

16. Informant Mrs Maggie Wagner
Address Upper Milla, Carroll Co. Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof July 18, 1940 (month) (day) (year)
Cemetery or crematory Stone Chapel Cemetery
Location Warfieldsburg
18. Funeral director H Bankard & Son
Address Westminster, Maryland
19. July 16 1940 Margaret R. Englar
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 16, 1940, at 6:15 AM
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 3 1940, to July 16, 1940, and that I last saw h[illegible] alive on July 15 1940.

Immediate cause of death	DURATION
Acute Cardiac Dilatation	
Due to Chronic Myocarditis	?
Due to Hypertensive Cardiovascular Dis	?
Other conditions	

(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Clifford M. Taylor, M. D. or other
Address Westminster, Md Date signed 7/16/40

RECEIVED
AUG 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07420

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 2 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 1 month, 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Maugansville
(If outside city or town limits, write RURAL and give nearest town)
Street No. ------
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME
Samuel D. Hartranft

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Not known
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): August 2, 1875

8. AGE: Years	Months	Days	If less than one day
64	11	6	..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business: --

FATHER
12. Name: Owen Hartranft
13. Birthplace: Pennsylvania

MOTHER
14. Maiden name: Annie Huntsburger
15. Birthplace: Maryland

16. Informant: Springfield State Hospital
Address: Sykesville, Maryland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 10, 1940 (month) (day) (year)
Cemetery or crematory: Rose Hill
Location: Hagerstown Md
18. Funeral director: H. K. Coffman
Address: Hagerstown Md.
19. July 8 1940 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 8th 1940 at 8:05 a.m.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 6 1940 to July 8 1940 and that I last saw him alive on July 8, 1940

Immediate cause of death	DURATION
General Paresis	At least 5 yrs.
Due to	
Due to	
Other conditions: Cerebral Arteriosclerosis ?	
Malaria, therapeutic (Include pregnancy within 3 months of death)	6/25/40

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: M. Virginia Beyer M.D.
M. D. or other
Address: Sykesville, Md Date signed: 7-8-40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
AUG 3 1940
U. S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-E)

CERTIFICATE OF DEATH

07421

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch
Stay in hospital or inst. (yrs., or mos., or days): 3 mos., 8 days.
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 628 N. Gilmor St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: none

3. (a) FULL NAME: ROSALIE HENDERSON

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col.	single

6 (b) Name of husband or wife:
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 7, 1926

8. AGE: Years	Months	Days	If less than one day
13	8	28	hrs. min.

9. Birthplace: Catonsville, Md. (Town, county, and state)

10. Usual occupation: Scholar

11. Industry or business: --

FATHER
12. Name: Joseph Henderson
13. Birthplace: Catonsville, Md.

MOTHER
14. Maiden name: Rosie Burton
15. Birthplace: Catonsville, Md.

16. Informant: Dr. Reuben Hoffman
Address: Henryton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-9-40 (month) (day) (year)
Cemetery or crematory: Western Star Cem.
Location: Balto. Co.

18. Funeral director: Saml. W. Geary & Son
Address: 638 N. Gilmor St.

19. 7/5/40 (Date rec'd by registrar) 19
Albert R. Swanke Registrar
Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 5, 1940 19, at 4:30 a.m. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 27, 1940 19, to July 5, 1940, and that I last saw her alive on July 5, 1940 19

Immediate cause of death: Pulmonary tuberculosis — DURATION: Sept. 1939

Due to: --

Due to: --

Other conditions: --

(Include pregnancy within 3 months of death)

Major findings:
Of operations: --

Of autopsy: --

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: -- Date of:
Where did injury occur? -- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): --
Means of injury: -- Injured at work?

23. SIGNATURE: Reuben Hoffman, M. D.
M. D. or other
Address: Henryton, Md.
Date signed: 7/5/40

RECEIVED
JUL 8 1940
BUREAU V, A.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

07422

Reg. Dist. No. 24

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Springfield State Hospital

Stay in hospital or inst. (yrs., or mos., or days): 36 years

Stay in this community (yrs., or mos., or days): 36 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore City

City or town: Baltimore Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 1208 N. Bond

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Wilhelmina Hildebrand

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6 (b) Name of husband or wife

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): 1872

8. AGE: Years	Months	Days	If less than one day
68			____ hrs. ____ min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: None.

11. Industry or business

FATHER — 12. Name: Noah Hildebrand

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Wilhelinina Straus

15. Birthplace: Germany

16. Informant: Hospital records

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 17, 1940 (month) (day) (year)

Cemetery or crematory: London Park Cemtery

Location: Balto. Md.

18. Funeral director: Wm Cook

Address: 1217 St Paul St Balto Md

19. July 15 1940 (Date rec'd by registrar) C. Harry Weu Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 14, 1940, at 9:03 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 14, 1904 to July 14, 1940

and that I last saw her alive on July 14, 1940

Immediate cause of death: Bronchopneumonia — DURATION: 4 days

Due to

Due to

Other conditions: Epilepsy — 67 yr

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy: As above

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: Joseph H. Marshall, M.D. M. D. or other

Address: Springfield State Hospital Date signed 7-15-40

RECEIVED
JUL 17 1940
BUREAU V. R.

07423

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

13-C

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Sykesville

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Springfield State Hospital

Stay in hospital or inst. (yrs., or mos., or days) 7 yrs., 5 mos., 12 days

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore City

City or town Baltimore City Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 3910 Boarman Avenue

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Margaret Holley

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife ------

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) December 11, 1912

8. AGE:

Years	Months	Days	If less than one day
27	7	11	____ hrs. ____ min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual occupation None

11. Industry or business -----

FATHER

12. Name James J. Holley

13. Birthplace Baltimore, Maryland

MOTHER

14. Maiden name Adelaide Roe

15. Birthplace Baltimore, Maryland

16. Informant Records of Springfield State Hospital, Sykesville, Md.

Address

17. Cremation (Burial, cremation, or removal. Which?) Date thereof 7-25-40 (month) (day) (year)

Cemetery or crematory Loudon Park

Location

18. Funeral director Henry Sorder + Son

Address 1649 E. Natch Ave.

19. July 22 1940 G. Harry Wren (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 22nd 1940, at 11:25 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 10 1933, to July 22nd 1940, and that I last saw her alive on July 22nd, 1940.

Immediate cause of death	DURATION
Pulmonary Tuberculosis	June, 1939.
Due to	
Due to	
Other conditions Epilepsy	Childhood

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE Alan Jacobson, M.D. M. D. or other

Address U.S.A. Date signed 7/23/40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUL 27 1920
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07424

Reg. Dist. No. 81c

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll Co.
City or town: Lineboro Md
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: County:
City or town: Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Mrs. Anna M. Hollingsworth

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Black	Married

6 (b) Name of husband or wife: Henry Hollingsworth
B(c) If alive, give age: 85 years

7. Birth date of deceased (mo., day, yr.): Apr 1 1864

8. AGE: Years	Months	Days	If less than one day
76	3	9	hrs. min.

9. Birthplace: Carroll Co
(Town, county, and state)
10. Usual occupation: House Wife
11. Industry or business:
FATHER 12. Name: Robert Williams
13. Birthplace: Carroll Co Md
MOTHER 14. Maiden name: Eliza Sanders
15. Birthplace: Maryland
16. Informant: Eliza Hollingsworth
Address: Lineboro Md
17. (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)
Cemetery or crematory: Mt Olive
Location: New Windsor Md
18. Funeral director: Raymond K. Wright
Address: Union Bridge Md
19. July 11 1940 (Date rec'd by registrar) Blackman Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 7-10-1940, at 5:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7-1-1940, to 7-10-1940, and that I last saw her alive on 7-9-1940.

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: J. H. Fegy M.D.
M. D. or other
Address: Union Bridge Date signed: 7-11-40

RECEIVED
AUG 6 1940
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07425

(13)

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Henryton (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch

Stay in hospital or inst. (yrs., or mos., or days) 4 days

Stay in this community (yrs., or mos., or days) Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County

City or town Baltimore Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. 633 Smithson St. (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Samuel Charles Howard

3. (b) Social Security Number 214-14-5137

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
male	colored	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 22, 1921

8. AGE:

Years	Months	Days	If less than one day
19	1	14	hrs. min.

9. Birthplace Marley Neck, Md. (Town, county, and state)

10. Usual occupation Dish washer

11. Industry or business Unknown

FATHER
12. Name Samuel Howard
13. Birthplace Maryland

MOTHER
14. Maiden name Jannie Jackson
15. Birthplace Maryland

16. Informant Reuben Hoffman, M.D.

Address Henryton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7 - 10 - 40 (month) (day) (year)

Cemetery or crematory Mt. Calvary St

Location A A C Md

18. Funeral director Isaiah L. Brown & Son

Address 108 W. Montgomery St.

19. July 6 1940 (Date rec'd by registrar) Albert R. Swankham Registrar Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH July 6, 1940 19 6:15 P.M., at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 3 1940, to July 6 1940, and that I last saw him alive on July 6 1940.

Immediate cause of death: Pulmonary tuberculosis

Due to --

Due to --

Other conditions --

(Include pregnancy within 3 months of death)

Major findings:

Of operations --

--

Of autopsy --

DURATION: April 1940

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide -- Date of --

Where did injury occur? -- (City or town) -- (County) -- (State)

Injured at home, farm, industry, public place (where?) --

Means of injury -- Injured at work? --

23. SIGNATURE Reuben Hoffman, M.D. Superintendent M. D. or other

Address Henryton, Md. Date signed 7/6/40

RECEIVED
JUL 18 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (183)

07426

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:

County Carroll

City or town Rural - Westminster
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Spring Mills

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) Life

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Rural - Westminster Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. Spring Mills
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR None

3. (a) FULL NAME John Stewart Ihex

3. (b) Social Security Number None

4. Sex Male

5. Color or race White

6. (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 25, 1921

8. AGE: Years 18 Months 8 Days 3 If less than one day hrs. min.

9. Birthplace Westminster Carroll Md
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business Farm

FATHER
12. Name John W. Ihex
13. Birthplace Maryland

MOTHER
14. Maiden name Rosie Virginia Mesbaum
15. Birthplace Maryland

16. Informant John W. Ihex
Address Westminster Md

17. Burial Date thereof 7/31/40
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Westminster Cemetery

Location Westminster, Maryland

18. Funeral director J. Francis Reese

Address Westminster, Md.

19. 7/29 1940 L. H. Woodward
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 28 1940, at about 12 noon

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 , to 19 ,
and that I last saw h alive on 19

Immediate cause of death Accidental Drowning

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations None

Of autopsy No

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of July 28/40

Where did injury occur? Mr. Westminster Carroll Md
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) John S. Hyde Farm

Means of injury Drowning Injured at work? No

23. SIGNATURE Jas. T. Marsh - Deputy Medical Examiner
M. D. or other

Address New Windsor Md Date signed July 28/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
AUG 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

07427

Reg. Dist. No. 83

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Rural - nr. Woodbine Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or Institution:

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 3 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Rural - Taylorsville Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: R. D. New Windsor, Md.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: No.

3. (a) FULL NAME: Cornelius Wesley Jenkins

3. (b) Social Security Number: No.

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Married.

6 (b) Name of ~~husband~~ or wife: Margaret E. Jenkins

6(c) If alive, give age: 84 years

7. Birth date of deceased (mo., day, yr.): Dec. 1, 1856

8. AGE:

Years	Months	Days	If less than one day
83	7	2	____ hrs. ____ min.

9. Birthplace: Carroll Co. Maryland
(Town, county, and state)

10. Usual occupation: Retired Carpenter

11. Industry or business

FATHER 12. Name: Cornelius Jenkins

13. Birthplace: Maryland.

MOTHER 14. Maiden name: Mary E. Fraver

15. Birthplace: Maryland.

16. Informant: Mr. James Jenkins

Address: Woodbine, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 5, 1940 (month) (day) (year)

Cemetery or crematory: Taylorsville

Location: Taylorsville, Carroll Co. Md.

18. Funeral director: C. M. Walsh

Address: Manchester Md.

19. July 5th 1940 (Date rec'd by registrar) Edna M. Hewitt Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 3 1940, at 11:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 2nd 1940, to July 3rd 1940, and that I last saw h[illegible] alive on July 3rd 1940.

Immediate cause of death	DURATION
Acute Endocarditis	
Due to	
Due to	
Other conditions: Chronic Interstitial Nephritis	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: L. C. Dulcky M. D. or other

Address: New Windsor Md. Date signed 7/3/40

RECEIVED
AUG 5 1940
BUREAU V. S.

07428

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-C)

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 months, 15 days

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 3 months, 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore City (If outside city or town limits, write RURAL and give nearest town)

Street No.: 2824 St. Paul Street (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Arthur M. Johnson

3.(b) Social Security Number:

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Not known

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): November 11, 1870

8. AGE: Years 69 | Months 8 | Days 0 | If less than one day ..... hrs. ..... min.

9. Birthplace: Massachusetts (Town, county, and state)

10. Usual occupation: Dean of Engineering Dept.,

11. Industry or business: University of Md.

FATHER: 12. Name: David Johnson

13. Birthplace: Massachusetts

MOTHER: 14. Maiden name: Amanda Malvina Richardson

15. Birthplace: Massachusetts

16. Informant: Springfield State Hospital

Address: Sykesville, Maryland.

17. Cremation (Burial, cremation, or removal. Which?) Date thereof: July 13/40 (month) (day) (year)

Cemetery or crematory: London Park

Location: Baltimore Md.

19. Funeral director: John O'Mitchell Thos

Address: 1900 Eutaw Place

19. July 11 1940 (Date rec'd by registrar) C. Harry Weir Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 11 1940, at 6:10 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 26 1940, to July 11 1940 and that I last saw him alive on July 10 1940

Immediate cause of death	DURATION
Arteriosclerosis.	Unknown
Chronic Myocarditis	Unknown
Due to	
Due to	
Other conditions	
Paralysis Agitans	8 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Lewis Danziger, M.D. M. D. or other

Address: Sykesville, Md. Date signed: 7-11-40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
AUG 3 1940
BUREAU A. S.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (730)

07429

CERTIFICATE OF DEATH

Reg. Dist. No. 80

1. PLACE OF DEATH:

County Carroll

City or town New Windsor
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 60 m

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll

City or town New Windsor Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Charles Jones

3. (b) Social Security Number none

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of ~~husband~~ or wife Margaret H. Maynard

B(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 10 1858

8. AGE: Years 82 Months 2 Days 29 If less than one day hrs. min.

9. Birthplace Frederick Co. Maryland
(Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER
12. Name ~~Frank~~ Francis Dorsey Jones
13. Birthplace Maryland

MOTHER
14. Maiden name Harriet Downey
15. Birthplace Fred. Co.

16. Informant Mrs Rose Caylor

Address New Windsor Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 12-1940 (month) (day) (year)

Cemetery or crematory Presbyterian Cemetery

Location New Windsor, Maryland

18. Funeral director H Bankard & son

Address Westminster, Maryland

19. July 12 1940 (Date rec'd by registrar) Oscar S Bradut Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 9 1940, at 1:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 1938, to July 9 1940, and that I last saw him alive on July 8 1940.

Immediate cause of death: Auricular Fibrillation — DURATION: 1 day

Due to: Chronic Myocarditis — 4 yrs.
Arteriosclerosis — yrs.

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings:
Of operations None

Of autopsy None

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

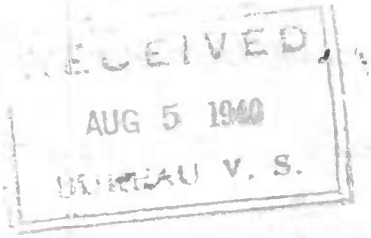
Means of injury — Injured at work? —

23. SIGNATURE Jas. T. Marsh M. D.
M. D. or other

Address New Windsor Md Date signed 7/9/40

Authorization to add sex and color of deceased - letter in permanent file under Jos. T. Marsh

11/6/40
M.G.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07430

Reg. Dist. No. 75

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Manchester Rural (If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 10 years

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Near Manchester Ward No. (If outside city or town limits, write RURAL NEAR and give town)
Street No.: Rural (If rural give LOCATION)
2(c) IF VETERAN, NAME WAR: —

3. (a) FULL NAME: Morris L. Jones

3. (b) Social Security Number: None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Single

B (b) Name of husband or wife: —
6(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Jan. 1st 1883

8. AGE: Years: 57 | Months: 6 | Days: 27 | If less than one day: ____ hrs. ____ min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Clerk
11. Industry or business: Cigar Store

FATHER
12. Name: David Jones
13. Birthplace: Wales, England

MOTHER
14. Maiden name: Eliza Harris
15. Birthplace: Wales, England.

16. Informant: Miss Edna Jones
Address: Manchester Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-30-40 (month) (day) (year)
Cemetery or crematory: Cemetery
Location: Manchester Md.

18. Funeral director: Jacob Whinks Sons
Address: Manchester Md.

19. July 29 1940 (Date rec'd by registrar) Mrs. W. P. J. Donner Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 28 1940, at 3A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1 1940, to July 28 1940, and that I last saw him alive on July 27 1940

Immediate cause of death	DURATION
Carcinoma Stomach	3 mos
Due to: metastasis to liver & peritoneum	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: W R S Donner
Address: Manchester Md M. D. or other
Date signed: 7/29/40

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (107)

07431

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 14 yrs., 10 mos., 14 days
Hospital, Institution, or street address where death occurred: Springfield State Hospital
How long in hospital or institution? 14 yrs., 10 mos., 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore City
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1620 Shakespear St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Matthew Krayger

3. (b) Social Security Number:

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): 1902

8. AGE: Years: 38 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Maryland
(Town, county, and state)
10. Usual occupation: None
11. Industry or business:
FATHER
12. Name: John Krayger
13. Birthplace: Poland
MOTHER
14. Maiden name: ?
15. Birthplace: Poland
16. Informant: Hospital records.
Address: Sykesville Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 3, 1940 (month) (day) (year)
Cemetery or crematory: Holy Cross National Cemetery
Location: Trappe Road.
18. Funeral director: Denkell & Hippel
Address: 312 S. Highland ave
19. Aug. 1 1940 (Date rec'd by registrar) C. Harry Weir Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 31, 1940 at 12:20 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sep. 17, 1925 to July 31, 1940 and that I last saw him alive on July 31, 1940

Immediate cause of death	DURATION
Bronchopneumonia	2 days
Due to	
Due to	
Other conditions: Epilepsy	Life

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Joseph H. Marshall, M.D. M. D. or other
Address: Springfield State Hospital Date signed: 7-31-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 (T)

RECEIVED
AUG 3 1940
BUREAU V. S.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (8)

07432

CERTIFICATE OF DEATH

Reg. Dist. No. 72.

1. PLACE OF DEATH:

County Carroll

City or town Myers Dist. Westminster, R.D. 2
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland. County Carroll

City or town Myers Dist. Westminster Md R.D. 2 Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Premature Birth Krumrine

3. (b) Social Security Number

4. Sex Male

5. Color or race White

6. (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1-1940

8. AGE: Years — Months — Days — If less than one day hrs. min.

9. Birthplace Carroll Co. Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name Oscar Krumrine
13. Birthplace Carroll Co. Md.

MOTHER
14. Maiden name Treva Stewart
15. Birthplace Carroll Co. Md

16. Informant Oscar Krumrine
Address Westminster, Md R.D. 2

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof July 1-1940
(month) (day) (year)

Cemetery or crematory Burried at Home

Location Carroll Co. Westminster Md R.D. 2

18. Funeral director J. W. Little & Son
Address Littlestown, PA. Per R.A.L.

19. July 2nd. 1940. Calvin E. Bennett,
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH unknown July 1, 1940, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 , to 19 ,
and that I last saw h alive on 19 .

Immediate cause of death

Still born

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE H. E. Gettner M.D.
M. D. or other
Address Littlestown Pa Date signed 7/1/40

RECEIVED
AUG 2 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (8)

07433

CERTIFICATE OF DEATH

Reg. Dist. No. 71

1. PLACE OF DEATH:
County Carroll Co
City or town Near Linwood
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Carroll
City or town Near Linwood Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Lambert

3. (b) Social Security Number

4. Sex ?
5. Color or race W
6. (a) Single, married, widowed, or divorced Single
6 (b) Name of husband or wife None
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 7-21-40
8. AGE: Years 0 Months 0 Days 0 If less than one day 0 hrs. 0 min.
9. Birthplace Near Linwood (Town, county, and state)
10. Usual occupation None
11. Industry or business
FATHER 12. Name Harry E Lambert
13. Birthplace Carroll Co
MOTHER 14. Maiden name Lucy Jane Wolfe
15. Birthplace Carroll Co
16. Informant Lucy Jane Wolfe
Address Near Linwood
17. (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)
Cemetery or crematory
Location On premises
18. Funeral director Self
Address
19. 7/22 19 40 Margaret R. Englar
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-21-40 19 , at M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 , to 19 ,
and that I last saw h alive on 19 .
Immediate cause of death STILL BORN
Due to 2 mons
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. H. Legg M.D.
M. D. or other
Address Union Bridge Date signed 7-21-40

VS A15 MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
AUG 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (136)

CERTIFICATE OF DEATH

07434

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch
Stay in hospital or inst. (yrs., or mos., or days): 4 mos., 10 days
Stay in this community (yrs., or mos., or days): Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 651 W. Mulberry St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: AVON BERNARD LEVI

3. (b) Social Security Number: 219-03-5846 (Colored) None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6 (b) Name of husband or wife:
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): November 25, 1910

8. AGE:

Years	Months	Days	If less than one day
29	7	27	hrs. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: Unknown

FATHER
12. Name: Charles Levi
13. Birthplace: unknown

MOTHER
14. Maiden name: Beatrice Watty
15. Birthplace: Baltimore, Maryland

16. Informant: Wm. A. Ventimiglia, M. D.
Address: Henryton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 25-40 (month) (day) (year)
Cemetery or crematory: Mt Calvary
Location:
18. Funeral director: Sam'l W. Chase & Son
Address: 638 N. Gilmor St

19. July 21 1940 (Date rec'd by registrar) Albert R. Swankhaus Registrar
Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 21, 1940 8:00 P.M. 19 , at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 11 1940, to July 21 1940, and that I last saw him alive on July 21, 1940 19

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Dec. 1939
Due to --	
Due to --	
Other conditions --	

(Include pregnancy within 3 months of death)

Major findings:
Of operations --
Of autopsy --

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide -- Date of --
Where did injury occur? -- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) --
Means of injury -- Injured at work? --

23. SIGNATURE Wm. A. Ventimiglia M. D. M. D. or other
Address: Henryton, Maryland Date signed 7/21/40

RECEIVED
AUG 3 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

07435

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Freedom, Md

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 7 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Freedom Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: R.D. Sykesville Md

(If rural, give LOCATION)

2(a) IF VETERAN, NAME WAR: No

3. (a) FULL NAME: Annie Margaret Linton

3. (b) Social Security Number: None

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or ~~wife~~: James E. Linton

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 20, 1856

8. AGE: Years: 83 Months: 11 Days: 24 If less than one day: hrs. min.

9. Birthplace: Baltimore Co. Maryland (Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER

12. Name: George Lyon

13. Birthplace: Germany

MOTHER

14. Maiden name: Katherine Smith

15. Birthplace: Germany

16. Informant: Mr. Walter Linton

Address: Sykesville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 21 1940 (month) (day) (year)

Cemetery or crematory: Freedom

Location: Freedom, Carroll Co. Md.

18. Funeral director: C.M. Waltz

Address: Winfield, Md.

19. July 19 1940 (Date rec'd by registrar) C. Harvey Steer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 18 1940, at 5 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1939, to July 18 1940, and that I last saw h~~im~~ alive on July 15 1940

Immediate cause of death: Cardio-vascular disease

DURATION

Cerebral arteriosclerosis

Senile dementia

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Jas. E. Masters M. D. or other

Address: Randallstown Date signed 7/19/40

RECEIVED
AUG 3 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-E)

CERTIFICATE OF DEATH

07436

Reg. Dist. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: rural near Westminster
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 50 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: rural near Westminster Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Frederick Magin

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowed

6 (b) Name of husband or wife: Katherine E. Niner

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 16, 1864

8. AGE: Years	Months	Days	If less than one day
75	7	12	hrs. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER
12. Name: Peter Magin
13. Birthplace: Germany

MOTHER
14. Maiden name: Not known
15. Birthplace

16. Informant: Clarence W. Magin
Address: Westminster, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof 7/31/40 (month) (day) (year)

Cemetery or crematory: Deer Park Cemetery

Location: Smallwood, nr. Westminster

18. Funeral director: J. Francis Reese
Address: Westminster, Md.

19. 7/28/40 (Date rec'd by registrar) Elwood Reed Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 28, 1940, at 11p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1938, to July 28 1940, and that I last saw h- im alive on July 28 - 1940

Immediate cause of death: Myocarditis (chr.) Nephritis (chr.) — DURATION: 2 yrs.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Ot operations: None

Ot autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: None Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: W. C. Jennette, M.D.
M. D. or other

Address: Westminster Date signed 7-29-40

RECEIVED
AUG 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-C)

07437

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:
County Carroll
City or town Westminster
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 255 E. Main Street
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 80

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Westminster Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 255 E. Main
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Martha Alice Magin

3. (b) Social Security Number none

4. Sex: F
5. Color or race: W
6. (a) Single, married, widowed, or divorced: widow
6 (b) Name of husband or wife: Charles Magin
6(c) If alive, give age ____ years
7. Birth date of deceased (mo., day, yr.): Aug. 23 - 1859
8. AGE: Years 80 Months 10 Days 14 If less than one day ____ hrs. ____ min.
9. Birthplace: Mr Westminster Carroll Co. Md.
(Town, county, and state)
10. Usual occupation: none
11. Industry or business
FATHER
12. Name: Philip Seipp
13. Birthplace: Germany
MOTHER
14. Maiden name: Elizabeth Zincon
15. Birthplace: Germany
16. Informant: Charles A. Magin
Address: 255 E. Main St Westminster, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof July 10-1940 (month) (day) (year)
Cemetery or crematory: Westminster Cemetery
Location: Westminster, Maryland.
18. Funeral director: H Bankard Hson
Address: Westminster Maryland.
19. 7/9 1940 (Date rec'd by registrar) L. Woodward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 8 1940, at 2 a.m.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 15 1940, to July 8 1940, and that I last saw her alive on July 7 1940.
Immediate cause of death: Acute Cardiac Dilatation. — DURATION: 1 day
Due to: Chronic myocarditis — Several years
Due to: Chronic Interstitial Nephritis — Five years
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Chas R Foutz M.D. M. D. or other
Address: Westminster Date signed 7/8/40

VS A15 (T)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
AUG 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (47-D) ✓

07438

CERTIFICATE OF DEATH

Reg. Dist. No. 77

1. PLACE OF DEATH:

County: Carroll

City or town: Hampstead Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days): 13 yrs 3 mo.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Hampstead Md. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. —
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR —

3. (a) FULL NAME: Alexander Martin

3. (b) Social Security Number: —

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of ~~husband~~ or wife: Barbara E Martin

6(c) If alive, give age: 67 years

7. Birth date of deceased (mo., day, yr.): October 1, 1866

8. AGE: Years: 73 Months: 9 10 Days: 30 If less than one day: hrs. min.

9. Birthplace: Cedar Grove, Balto Co. Maryland
(Town, county, and state)

10. Usual occupation: Retired farmer

11. Industry or business: Agriculture

FATHER
12. Name: Cornelius Martin
13. Birthplace: Maryland.

MOTHER
14. Maiden name: Rebecca Nace
15. Birthplace: Maryland.

16. Informant: Barbara E. Martin

Address: Hampstead Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 2/40 (month) (day) (year)

Cemetery or crematory: Black Rock

Location: Butler Md

18. Funeral director: Edw C Tipton

Address: Hampstead Md

19. August 1 1940 (Date rec'd by registrar) Mildred S. Hughes (deputy) Registrar

MEDICAL CERTIFICATION:

20. DATE OF DEATH: July 31 1940, at 11 55 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 4 1939, to July 31 1940, and that I last saw him alive on July 31, 1940.

Immediate cause of death: Carcinoma of Lung. — DURATION: ?

Due to

Due to

Other conditions: Arterio-Sclerotic Cardio-vascular disease — ?
(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide — Date of —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE: Joseph E. Bush M.D.
M. D. or other

Address: Hampstead Md Date signed: 7-31-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
SEP 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (132)

07439

CERTIFICATE OF DEATH

Reg. Dist. No. 74

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch
Stay in hospital or inst. (yrs., or mos., or days): 5 mos., 18 days
Stay in this community (yrs., or mos., or days): Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 1402 Bruce Street
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Esther Martin

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married (separated)

6 (b) Name of husband or wife: Unknown
6(c) If alive, give age: Unknown years

7. Birth date of deceased (mo., day, yr.): July 24, 1915

8. AGE: Years	Months	Days	If less than one day
24	11	20	hrs. min.

9. Birthplace: Columbia, South Carolina
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Unknown

FATHER
12. Name: Edward James
13. Birthplace: South Carolina

MOTHER
14. Maiden name: Narcissa Camel
15. Birthplace: South Carolina

16. Informant: Dr. Reuben Hoffman
Address: Henryton, Maryland

17. Cremation (Burial, cremation, or removal. Which?) Date thereof 7/16-1940 (month) (day) (year)
Cemetery or crematory: city morgue
Location: Balto md
18. Funeral director: Mrs Samuel T. Hemly
Address: 578 W. Biddle Street

19. 7/14/40 (Date rec'd by registrar) 19 Albert R. Frankhauser Registrar
Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 14, 1940 19 at 6:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 26, 1940 to July 14 1940, and that I last saw her alive on July 14, 1940 19

Immediate cause of death: Pulmonary Tuberculosis — DURATION: Sept. 1939
Due to: --
Due to: --
Other conditions: --
(Include pregnancy within 3 months of death)
Major findings: --
Of operations: --
Of autopsy: --

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: -- Date of: --
Where did injury occur? -- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): --
Means of injury: -- Injured at work? --

23. SIGNATURE: Reuben Hoffman M.D.
Superintendent M. D. or other
Address: Henryton, Maryland Date signed: 7/14/40

RECEIVED
AUG 3 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

07440

CERTIFICATE OF DEATH

Reg. Dist. No. 24

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Springfield State Hospital
Stay in hospital or inst. (yrs., or mos., or days): 16 yrs., 5 mos., 2 days
Stay in this community (yrs., or mos., or days): 16 yrs., 5 mos., 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Howard
City or town: Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Kate McKavey

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

B (b) Name of husband or wife: Mc Kavey
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): About 1865

8. AGE:

Years	Months	Days	If less than one day
75			hrs. min.

9. Birthplace: Salem, N. J. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business
FATHER 12. Name: Martin Donley
13. Birthplace: Ireland
MOTHER 14. Maiden name: Annie Hart
15. Birthplace: Ireland
16. Informant: Hospital records
Address: Sykesville, Md.
17. Buried (Burial, cremation, or removal. Which?) Date thereof July 8, 1940 (month) (day) (year)
Cemetery or crematory: Springfield Hospital Cemetery
Location: Sykesville Md
18. Funeral director: C. Harry Weis
Address: Sykesville Md.
19. July 8 1940 (Date rec'd by registrar) C. Harry Weis Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 3, 1940, at 10:50 AM
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Feb. 1, 1934 to July 3, 1940, and that I last saw her alive on July 2, 1940

Immediate cause of death	DURATION
Hypertensive cardiovascular disease	15 yrs.
Cerebral hemorrhage	5 days
Due to Hypostatic pneumonia	1 day
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Ot operations
Ot autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: Joseph H. Marshall, M.D. M. D. or other
Address: Springfield State Hospital Date signed 7-3-40

RECEIVED
AUG 3 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07441

13-P

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 mos., 6 days

Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch

How long in hospital or institution? 9 mos, 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1433 Myrtle Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: BESSIE REBECCA MC KENNEY

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6.(b) Name of husband or wife: Edward Mc Kenney

6.(c) If alive, give age: 57 years

7. Birth date of deceased (mo., day, yr.): December 12, 1889

8. AGE: Years	Months	Days	If less than one day
50	7	19	..... hrs. ..... min.

9. Birthplace: Lancaster, South Carolina
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: Unknown

FATHER
12. Name: Arron Johnson
13. Birthplace: Lancaster, South Carolina

MOTHER
14. Maiden name: Gene Clinton
15. Birthplace: Lancaster, South Carolina

16. Informant: Wm. A. Ventimiglia, M.D.
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 2 1940 (month) (day) (year)
Cemetery or crematory: Mt. Auburn
Location: Balto. Md.

18. Funeral director: Mrs S. T. Hemsley
Address: 578 N. Biddle St.

19. July 31, 1940 (Date rec'd by registrar) Albert R Swankhouse Registrar
Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 31, 1940 at 3:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 25 1939, to July 31 1940 and that I last saw her alive on July 31, 1940

Immediate cause of death: Pulmonary Tuberculosis — DURATION: Jan. 1939

Due to: --

Due to: --

Other conditions: --

(Include pregnancy within 3 months of death)

Major findings of operations: --

Date of op.: --

Autopsy results: --

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: -- Date of: --

Where did injury occur? --
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?): --

Means of injury: -- Injured at work? --

23. SIGNATURE: Wm. A. Ventimiglia M. D.
M. D. or other

Address: Henryton, Maryland Date signed: 7/31/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 115

RECEIVED
AUG 3 1940
BUREAU V. S.

07442

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (191)

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll.

City or town Sykesville, Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Springfield State Hospital.

Stay in hospital or inst. (yrs., or mos., or days) 5 yrs., 1 mo., 17 days.

Stay in this community (yrs., or mos., or days) Same.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland, County Washington.

City or town Hagerstown, Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 922 Summit Ave.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME John McLucas.

3. (b) Social Security Number #

4. Sex: Male.

5. Color or race: White.

6. (a) Single, married, widowed, or divorced: Widower.

6 (b) Name of husband or wife Elma Holliday.

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Unknown.

8. AGE: Years 50(?) | Months # | Days # | If less than one day ____ hrs. ____ min.

9. Birthplace Washington Co., Md.
(Town, county, and state)

10. Usual occupation Truck Driver.

11. Industry or business

FATHER
12. Name Thomas McLucas.
13. Birthplace Maryland.

MOTHER
14. Maiden name Mary A. Shoemaker.
15. Birthplace Maryland.

16. Informant Springfield Hospital Record.
Address Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 31 1940 (month) (day) (year)

Cemetery or crematory Hagerstown

Location Hagerstown Md

18. Funeral director Snyder & Rowland

Address Clear Spring Md.

19. July 29 1940 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 29, 1940, at 12 M (noon)

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 10, 1936, to July 29, 1940, and that I last saw him alive on July 29, 1940.

Immediate cause of death: Heat Exhaustion — one day.

Due to

Due to

Other conditions General Paresis — prior to 6-12-35
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE Harry F. Baer, M. D. M. D. or other

Address Sykesville, Md. Date signed 7-29-40.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
AUG 3 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

07443

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:
County Carroll
City or town Shipley
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Shipley Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Jesse Boyd Miller

3. (b) Social Security Number none

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
M	W	single

6 (b) Name of husband or wife —
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 13 - 1940

8. AGE: Years	Months	Days	If less than one day
—	—	5	hrs. min.

9. Birthplace Shipley Carroll Co. Maryland
(Town, county, and state)
10. Usual occupation —
11. Industry or business

FATHER
12. Name Melvin Miller
13. Birthplace Tenn.

MOTHER
14. Maiden name Maude Penley
15. Birthplace North Carolina

16. Informant Melvin Miller
Address Westminster, Maryland R.D. #6

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 18 1940 (month) (day) (year)
Cemetery or crematory Jion Cemetery
Location Shipley Carroll Co. Md.

18. Funeral director H. Bankard & Son
Address Westminster Maryland

19. 7/18 1940 (Date rec'd by registrar) L. Woodward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 18 - 1940, at 12:30 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 13 - 1940, to July 18 - 1940, and that I last saw him alive on July 17 - 1940.

Immediate cause of death Premature birth — DURATION 4 days

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations None
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide None Date of
Where did injury occur? None (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. C. Jennette M.D. M. D. or other
Address Westminster Date signed 7-18-40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
AUG 5 1940
U. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (58-d)

07444

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Springfield State Hospital
Stay in hospital or inst. (yrs., or mos., or days): 15 years, 2 mos., 18days
Stay in this community (yrs., or mos., or days): 15 years, 2 mos., 18days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 216 Saratoga
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Jane Morgan

3. (b) Social Security Number

4. Sex: female
5. Color or race: white
6. (a) Single, married, widowed, or divorced: single
6 (b) Name of husband or wife
6(c) If alive, give age ____ years
7. Birth date of deceased (mo., day, yr.): June 8, 1891

8. AGE: Years: 49 Months: 1 Days: 6 If less than one day ____ hrs. ____ min.

9. Birthplace: Allegany County, Md.
(Town, county, and state)
10. Usual occupation: Housework
11. Industry or business
FATHER
12. Name: James Morgan
13. Birthplace: Scotland
MOTHER
14. Maiden name: Ellen Templeton
15. Birthplace: Scotland
16. Informant: Mrs. Nellie M. Martin
Address: 216 Saratoga St., Cumberland, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof July 17 1940 (month) (day) (year)
Cemetery or crematory: Cumberland
Location: Md.
18. Funeral director: Louis Stein Inc.
Address: Cumberland Md.
19. July 15 1940 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 14, 1940, at 8:40P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 26, 1925, to July 14, 1940 and that I last saw her alive on July 14, 1940.

Immediate cause of death: Rheumatic heart disease with mitral and aortic insufficiency — DURATION: ~~Life~~ 15 yrs. known
Due to: Cardiac decompensation — 1 mo.
Due to:
Other conditions: Left hemiplegia following operation for brain tumor. — 17yrs
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ____ Date of ____
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ____ Injured at work?

23. SIGNATURE: Joseph H. Marshall, M.D. M.D. or other
Address: Springfield State Hospital Date signed: 7-14-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A16

RECEIVED
AUG 3 1940
BUREAU V. S.

07445

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(97)

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 yr. 9 mo. 5 da.

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 6 yrs. 9 mo. 5 da.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Balto. County

City or town Towson (If outside city or town limits, write RURAL and give nearest town)

Street No. Greenridge Avenue (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Florence R. Muller

3.(b) Social Security Number

4. Sex F.

5. Color or race W.

6.(a) Single, married, widowed, or divorced widowed

6.(b) Name of husband or wife Hamilton Muller

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Apr. 29 - 1858

8. AGE: Years 82 Months 2 Days 25 If less than one day ..... hrs. ..... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER 12. Name John Wesley Boone

13. Birthplace Maryland

MOTHER 14. Maiden name Susanna Dick

15. Birthplace Maryland

16. Informant Hospital Records

Address Sykesville Md

17. Burial (Burial, ~~cremation, or removal. Which?~~) Date thereof July 26th 1940 (month) (day) (year)

Cemetery ~~or crematory~~ London Park

Location Balto Md

16. Funeral director William Cook

Address 1217 St Paul St

19. July 23 1940 (Date rec'd by registrar) A. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 23 1940, at 1 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 16 1934, to July 23 1940 and that I last saw her alive on July 23 1940.

Immediate cause of death Arteriosclerosis — DURATION 7 yrs

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Maud M. Rees M.D. M. D. or other

Address Sykesville Md Date signed 7-23-40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
AUG 3 1940

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

95-C

07446

CERTIFICATE OF DEATH

Reg. Dist. No. 72

1. PLACE OF DEATH:

County Carroll

City or town Pleasant Valley
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 80 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State County

City or town Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Mrs Mary Jane Myers

3. (b) Social Security Number

4. Sex F

5. Color or race W

6. (a) Single, married, widowed, or divorced widow

8 (b) Name of husband or wife David D Myers

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 22, 1853

8. AGE: Years 86 Months 7 Days 28 If less than one day hrs. min.

9. Birthplace Md
(Town, county, and state)

10. Usual occupation Housework

11. Industry or business

FATHER
12. Name Emanuel Myers
13. Birthplace Md

MOTHER
14. Maiden name Catherine Erb
15. Birthplace Md.

16. Informant Upton E. Myers

Address Pleasant Valley

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 23, 1940 (Month) (day) (year)

Cemetery or crematory Pleasant Valley

Location Pleasant Valley

18. Funeral director C D Tusser Son

Address Taneytown Md

19. July 22nd 1940 (Date rec'd by registrar) Calvin E Bankert, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 20th 1940, at [illegible]

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1st 1940, to July 20 1940, and that I last saw her alive on July 20th 1940.

Immediate cause of death Angina Heart Disease

Due to Age

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE [illegible] M. D. or other

Address Westminster Md Date signed July 22 1940

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
AUG 2 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (134)

07447

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch

Stay in hospital or inst. (yrs., or mos., or days): 4 mos., 8 days

Stay in this community (yrs., or mos., or days): Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 145 W. Henrietta Street

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: none

3. (a) FULL NAME: Edward Nelson

3. (b) Social Security Number: 217-05-9636

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	Colored	Single

6 (b) Name of husband or wife:

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 1, 1913

8. AGE:

Years	Months	Days	If less than one day
27	6	11	hrs. min.

9. Birthplace: Summerton, South Carolina (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Unknown

FATHER

12. Name: Edward Nelson

13. Birthplace: Summerton, South Carolina

MOTHER

14. Maiden name: Julie Thomas

15. Birthplace: Summerton, South Carolina

18. Informant: Dr. Reuben Hoffman

Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-15-40 (month) (day) (year)

Cemetery or crematory: Mt Auburn Cem

Location: Balto City

18. Funeral director: Isaac L. Brown & Son

Address: 108 W Montgomery St

19. 7/12/40 19 (Date rec'd by registrar) Albert L. Swankhaus Registrar

Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 12, 1940 19 , at 6:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 4, 1940 19 , to July 12, 19 40

and that I last saw him alive on July 12, 1940 19

Immediate cause of death	Pulmonary Tuberculosis	Dec. 1939
Due to	--	
Due to	--	
Other conditions	--	

(Include pregnancy within 3 months of death)

Major findings:

Of operations: --

Of autopsy: --

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide -- Date of --

Where did injury occur? -- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) --

Means of injury -- Injured at work? --

23. SIGNATURE: Reuben Hoffman, M.D.

Superintendent M. D. or other

Address: Henryton, Maryland Date signed 7/12/40

RECEIVED
JUL. 19 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

CERTIFICATE OF DEATH

017448

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch
Stay in hospital or inst. (yrs., or mos., or days): 6 mos., 12 days
Stay in this community (yrs., or mos., or days): Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 938 Argyle Avenue
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: JAMES NELSON

3. (b) Social Security Number: 220-09-4830 (Col.)

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Mar[illegible]

6 (b) Name of husband or wife: Dorothy Nelson
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 16, 1915

8. AGE:

Years	Months	Days	If less than one day
24	9	11	hrs. min.

9. Birthplace: Summerton, South Carolina
(Town, county, and state)

10. Usual occupation: Laundry Worker

11. Industry or business: Unknown

FATHER
12. Name: James Edward Nelson
13. Birthplace: unknown

MOTHER
14. Maiden name: Julia Thomas
15. Birthplace: unknown

16. Informant: Wm. A. Ventimiglia, M. D.
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 30.40 (month) (day) (year)
Cemetery or crematory: Mt Auburn
Location: Balto Md
18. Funeral director: Isaiah L Brown Son
Address: 108 W Montgomery St

19. July 27, 1940 (Date rec'd by registrar) Albert R. Swanckhaus Registrar

Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 27, 1940 at 1:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 15 1940 to July 27 1940, and that I last saw him alive on July 27 1940

Immediate cause of death: Pulmonary Tuberculosis — DURATION: May 1939

Due to: --

Due to: --

Other conditions: --

(Include pregnancy within 3 months of death)

Major findings:
Of operations: --
Of autopsy: --

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: -- Date of: --
Where did injury occur? -- (City or town) -- (County) (State)
Injured at home, farm, industry, public place (where?): --
Means of injury: -- Injured at work? --

23. SIGNATURE: Wm. A. Ventimiglia M.D. M. D. or other
Address: Henryton, Maryland Date signed 7/27/40

RECEIVED
AUG 1 1940
BUREAU W. S.

07449

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (110-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 mo

Hospital, institution, or street address where death occurred: Springfield Hosp State

How long in hospital or institution? 3 mo

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md County: Alleghany

City or town: Mt Savage (If outside city or town limits, write RURAL and give nearest town)

Street No. — (If rural, give LOCATION)

2.(a) If veteran, name war —

3. (a) FULL NAME: Annie Norris

3. (b) Social Security Number:

4. Sex: female

5. Color or race: white

6.(a) Single, married, widowed, or divorced: married

6.(b) Name of husband or wife: David E Norris

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): March 26-1880

8. AGE: Years 60 | Months 4 | Days 1 | If less than one day ... hrs. ... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business:

FATHER
12. Name: John Kinerlem
13. Birthplace: Germany

MOTHER
14. Maiden name: Annie Krouse
15. Birthplace: Germany

16. Informant: David E Krouse

Address: Mt Savage Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 30 1940 (month) (day) (year)

Cemetery or crematory: Mt. Savage Md.

Location:

18. Funeral director: C H Weer

Address: Sykesville Md.

19. July 28 1940 (Date rec'd by registrar) A Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 28 1940, at 2:10 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 19th 1940, to July 28 1940 and that I last saw her alive on July 28th 1940

Immediate cause of death: Pleurisy with Effusion Empyema Generalized

Due to: Arterio Sclerosis

Other conditions

(Include pregnancy within 3 months of death)

DURATION: June 1st ?

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: H. Martin M. D. or other

Address: Sykesville Date signed: July 28/40

VS A15 (T) MARGIN RESERVED FOR BINDING (M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
AUG 3 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07450

Reg. Dist. No. 71

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Carroll
City or town Tyrone
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 70 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State County
City or town Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Mrs. Flora R. Nusbaum

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	married

6 (b) Name of husband or wife Geo. H. Nusbaum
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 21, 1865

8. AGE: Years	Months	Days	If less than one day
74	9	11	hrs. min.

9. Birthplace Md
(Town, county, and state)

10. Usual occupation housework

11. Industry or business

FATHER 12. Name Joshua Crawford
13. Birthplace Md

MOTHER 14. Maiden name Rebecca Frock
15. Birthplace Md

16. Informant Geo. H. Nusbaum
Address Westminster R.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 5, 1940 (month) (day) (year)
Cemetery or crematory Baust
Location Tyrone, Md.

18. Funeral director C. O. FUSS & SON
Address Taneytown, Md.

19. July 5 1940 (Date rec'd by registrar) Margaret R. Englar Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 2 1940 1940, at 10 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 14 1940 19 to July 2 1940, and that I last saw h alive on or about June 25 1940.

Immediate cause of death Cerebral Hemorrhage — DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. Hunt Stewart M. D. or other
Address Westminster Md Date signed July 5 1940

RECEIVED
AUG 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-D)

07451

CERTIFICATE OF DEATH

Reg. Dist. No. 83

1. PLACE OF DEATH:
County: Carroll
City or town: Rural Near Day
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 months
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Rural Near Day
(If outside city or town limits, write RURAL and give nearest town)
Street No. R.F.D. Woodbine
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Mary A. Pickett

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Thomas Pickett
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 18, 1867

8. AGE:

Years	Months	Days	If less than one day
73	5	4	..... hrs. ..... min.

9. Birthplace: Carroll Co. Md.
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER
12. Name: Conrad Krouning
13. Birthplace: Germany

MOTHER
14. Maiden name: Anna E. Bottner
15. Birthplace: Germany

16. Informant: Floyd Pickett
Address: Woodbine Md. R.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 26. 1940 (month) (day) (year)
Cemetery or crematory: Taylorsville
Location: Taylorsville Carroll Co. Md.

18. Funeral director: C. M. Walter
Address: Winfield Md.

19. July 24 (Date rec'd by registrar) 19.. D. Edna M. Hewitt Registrar
Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 22nd 19.40, at 6 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1st 19.40, to July 19th 19.40 and that I last saw h.. alive on July 19th 19.40

Immediate cause of death	DURATION
Paralysis	1 week
Due to	
Due to Chronic Interstitial Nephritis	One year
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: L. C. Shirley M. D. or other
Address: New Windsor Md. Date signed 7-23-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
AUG 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

07452

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch
Stay in hospital or inst. (yrs., or mos., or days) 5 mos., 22 days
Stay in this community (yrs., or mos., or days) Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 1011 Mc Donogh St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: none

3. (a) FULL NAME: CHARLES LEE POOLE

3. (b) Social Security Number: none 216-09-8991 (Rev.)

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Separated

6 (b) Name of husband or wife: Unknown

6(c) If alive, give age: Unknown years

7. Birth date of deceased (mo., day, yr.): April 23, 1896

8. AGE: Years	Months	Days	If less than one day
44	2	9	____ hrs. ____ min.

9. Birthplace: Lakesville, North Carolina
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Unknown

FATHER
12. Name: Jerry Poole
13. Birthplace: North Carolina

MOTHER
14. Maiden name: Lucinda Wood
15. Birthplace: North Carolina

16. Informant: Dr. Reuben Hoffman
Address: Henryton, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof July 6, 1940 (month) (day) (year)
Cemetery or crematory: Mt Calvary Cem
Location: a.a Co.

18. Funeral director: Rayner Sanders
Address: 14 1/2 E Preston St.

19. 7/2/40 19____ (Date rec'd by registrar) Albert R Swanborn Registrar
Superintendent

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 2, 1940 19____, at 10:25 p.m. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 10 19 40, to July 2 19 40, and that I last saw h- im alive on July 2, 1940 19____

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Aug. 1939
Due to --	
Due to --	
Other conditions --	

(Include pregnancy within 3 months of death)

Major findings:
Of operations --
Of autopsy --

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide -- Date of --
Where did injury occur? -- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury -- Injured at work? --

23. SIGNATURE: Reuben Hoffman, M.D.
M. D. or other
Address: Henryton, Maryland Date signed 7/2/40

RECEIVED
AUG 3 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07453

Reg. Diat. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch

Stay in hospital or inst. (yrs., or mos., or days): 1 month, 2 days

Stay in this community (yrs., or mos., or days): Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 420 George St.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: GEORGE NATHANIEL RANSON

3. (b) Social Security Number: 218-01-3157

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6 (b) Name of husband or wife:

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 28, 1921

8. AGE:

Years	Months	Days	If less than one day
19	5	22	hrs. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: Janitor

11. Industry or business: Unknown

FATHER

12. Name: Harrison Ranson

13. Birthplace: Maryland

MOTHER

14. Maiden name: Florence Dann

15. Birthplace: Anniston, Ala.

16. Informant: Reuben Hoffman, M.D.

Address: Henryton, Maryland

17. (Burial, cremation, or removal. Which?) Date thereof July 22 40 (month) (day) (year)

Cemetery or crematory: Mt Calvary Cem

Location:

18. Funeral director: A. Josephus Halsted

Address: 918 Druid Hill Ave.

19. July 19 19 40 (Date rec'd by registrar) Albert R. Swanckhaus Registrar

Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 19, 1940 19 , at 6:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 17, 19 40, to July 19, 19 40, and that I last saw him alive on July 19, 1940 19

Immediate cause of death	DURATION
Tbc. Meningitis--14 days	May 1940
Pulmonary Tuberculosis	
Due to --	
Due to --	
Other conditions --	

(Include pregnancy within 3 months of death)

Major findings:

Of operations --

Of autopsy --

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide -- Date of --

Where did injury occur? -- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) --

Means of injury -- Injured at work? --

23. SIGNATURE: Reuben Hoffman M.D. M. D. or other

Address: Henryton, Maryland Date signed 7/19/40

Superintendent

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
JUL 24 1940
BUREAU V.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07454

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch
Stay in hospital or inst. (yrs., or mos., or days): 6 months, 12 days
Stay in this community (yrs., or mos., or days): Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 811 S. Fremont St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Elizabeth Queen Samuel
3. (b) Social Security Number: None

4. Sex: Female
5. Color or race: Colored
6. (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Albert Samuel
6(c) If alive, give age: unknown years
7. Birth date of deceased (mo., day, yr.): June 27, 1917
8. AGE: Years 23 | Months 0 | Days 20 | If less than one day ___ hrs. ___ min.
9. Birthplace: Meekins Neck, Maryland (Town, county, and state)
10. Usual occupation: Sorter in Ray shop
11. Industry or business: Unknown
FATHER
12. Name: A. V. Duffin Chester
13. Birthplace: Chester, South Carolina
MOTHER
14. Maiden name: Lilly Bishop
15. Birthplace: Meekins Neck, Maryland
16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland
17. X (Burial, cremation, or removal. Which?) Date thereof: July 20 40 (month) (day) (year)
Cemetery or crematory: Mt Calvery
Location: Balto Co
18. Funeral director: Byron Wright
Address: 1218 Meeking St McElderry
19. July 17 1940 (Date rec'd by registrar) Albert R. Swankhaus Registrar Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 17, 1940 19 8:15 P.M., at M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 2, 1940 19 to July 17 19 40, and that I last saw her alive on July 17, 1940 19
Immediate cause of death: Pulmonary Tuberculosis — DURATION: Oct. 1939
Due to: --
Due to: --
Other conditions: --
(Include pregnancy within 3 months of death)
Major findings:
Of operations: --
Of autopsy: --

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: -- Cate of: --
Where did injury occur? -- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): --
Means of injury: -- Injured at work? --

23. SIGNATURE: Reuben Hoffman M.D. M. D. or other
Superintendent
Address: Henryton, Maryland Date signed: 7/17/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
AUG 3 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

07455

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 31 yrs
Hospital, institution, or street address where death occurred: Springfield State Hosp.
How long in hospital or institution? 31 yrs 4 mos

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Carroll
City or town: Mt. Airy Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: —
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME: Fannie Slack

3.(b) Social Security Number: —

4. Sex: female
5. Color or race: white
6.(a) Single, married, widowed, or divorced: widowed
6.(b) Name of husband or wife: William Slack
6.(c) If alive, give age: — years
7. Birth date of deceased (mo., day, yr.): 1863
8. AGE: Years: 77 Months: — Days: — If less than one day: hrs. min.
9. Birthplace: Monty Co Md. (Town, county, and state)
10. Usual occupation: Housemaid
11. Industry or business:
12. FATHER — Name: R. A. Nelson
13. FATHER — Birthplace: Maryland
14. MOTHER — Maiden name: Annie S. Shipley
15. MOTHER — Birthplace: Mary land
16. Informant: Mrs. J. H. Klein
Address: Mt. Airy Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 29, 1940 (month) (day) (year)
Cemetery or crematory: Prospect
Location: Near Mt. Airy Md.
18. Funeral director: C. M. Walter
Address: Winfield, Md.
19. July 27 1940 (Date rec'd by registrar) Catharine Keen Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 27th 1940 at 3-20 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 15 1939 to July 27 1940
and that I last saw her alive on July 27 1940
Immediate cause of death: Chronic Myocarditis — DURATION: 10 yrs
Due to: Generalized Arterio Sclerosis — DURATION: 2 yrs
Other conditions: Hypertension — DURATION: 8 yrs
(Include pregnancy within 3 months of death)
Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: W. H. Wastun M.D.
M. D. or other
Address: Sykesville Date signed: July 27/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
AUG 3 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (63-a)

07456

CERTIFICATE OF DEATH

Reg. Dist. No. 70

1. PLACE OF DEATH:

County Carroll

City or town Harney
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 50 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State County

City or town Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME J.William Slagenhaupt

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct.22,1853

8. AGE: Years	Months	Days	If less than one day
86	8	17	hrs. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual occupation retired school teacher

11. Industry or business

FATHER
12. Name Samuel Slagenhaupt
13. Birthplace Md.

MOTHER
14. Maiden name Mary Dayhoff
15. Birthplace Md

16. Informant Joseph Kelley
Address Harney,Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 12,1940 (month) (day) (year)

Cemetery or crematory United Brethren

Location Harney,Md.

18. Funeral director C.O.FUSS & SON
Address Taneytown,Md.

19. July 11 1940 (Date rec'd by registrar) Ethele M Mehrwey Registrar Local

MEDICAL CERTIFICATION Prior to

20. DATE OF DEATH July 9 1940, at 4P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ——— 19 ——— to ——— 19 ———, and that I last saw h ——— alive on ——— 19 ———.

Immediate cause of death

Cerebral Hemorrhage

Due to Arteriosclerosis

Due to

Other conditions —

(Include pregnancy within 3 months of death)

Major findings:

Of operations —

Of autopsy none

DURATION

—

—

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work? —

23. SIGNATURE Jas T. Marsh Deputy Medical Examiner
M. D. or other

Address New Windsor Md Date signed 7/9/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
AUG 2 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

117457

Reg. Dist. No. 76

1. PLACE OF DEATH:

County: Carroll

City or town: Westminster
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 255 E. Main St.

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 60 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Westminster Ward No.:
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 255 E. Main St.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Martha Ann Smith

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6 (b) Name of husband or wife: James E. Smith

6(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): August 3, 1849

8. AGE:

Years	Months	Days	If less than one day
90	11	20	____ hrs. ____ min.

9. Birthplace: Leesburg, Virginia
(Town, county, and state)

10. Usual occupation: none

11. Industry or business:

FATHER
12. Name: Not known
13. Birthplace: Leesburg, Va.

MOTHER
14. Maiden name: Not known
15. Birthplace: Leesburg Va.

16. Informant: Mrs. Claude T. Smith

Address: Westminster, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/25/40 (month) (day) (year)

Cemetery or crematory: Westminster, Cemetery

Location: Westminster, Md.

18. Funeral director: J. Francis Reese

Address: Westminster, Md.

19. 7/24 (Date rec'd by registrar) 1940 H. C. Woodward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 23 1940, at 9a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 20th 1940, to July 23rd 1940, and that I last saw her alive on July 23rd 1940.

	DURATION
Immediate cause of death: cerebral hemorrhage	5 min
Due to: Senility	5 years
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: C. L. Billingslea M. D. or other

Address: Westminster, Md. Date signed: 7/23/40.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
AUG 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(46-E)

07458

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:

County Carroll Co.

City or town Westminster
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 110 E. Green St.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 17 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Westminster Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 110 E. Green St.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR X

3. (a) FULL NAME Margaret Alice Stem

3. (b) Social Security Number X

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: single

B (b) Name of husband or wife X

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) July 25 1868

8. AGE: Years 71 Months 11 Days 26 If less than one day ____ hrs. ____ min.

9. Birthplace Sams Creek Carroll Co. Md.
(Town, county, and state)

10. Usual occupation none

11. Industry or business —

FATHER
12. Name David E. Stem
13. Birthplace Sams Creek Carroll Co. Md

MOTHER
14. Maiden name Margaret Van Buren Wilt
15. Birthplace Sams Creek Carroll Co. Md

16. Informant Arthur Albert

Address 110 E. Green St. Westminster

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7 22 40 Md. (month) (day) (year)

Cemetery or crematory Bethel Cemetery

Location Sams' Creek New Windsor Md.

18. Funeral director J. E. Myers Jr.

Address Westminster, Md.

19. 7/21 1940 [signature] Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 20 1940, at 7:20 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1939, to July 20 1940, and that I last saw her alive on July 19 1940.

Immediate cause of death Cancer of lower bowel.

Due to (metasis to various organs is assumed)

Due to

Other conditions Hypertension, with arterio-sclerosis & mental change deterioration
(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

CURATION Probably 18 mo.

PHYSICIAN Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE E. Reese Wilkens M. D. or other

Address Westminster Date signed July 20 1940

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
AUG 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07459

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch

Stay in hospital or inst. (yrs., or mos., or days): 1 month, 15 days

Stay in this community (yrs., or mos., or days): Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel Co.

City or town: Annapolis Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 79 Northwest Street

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Beatrice Marion Stevens

3. (b) Social Security Number 214-18-7056 (Mrs.) Home

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

B (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): March 11, 1909

8. AGE: Years: 31 | Months: 4 | Days: 18 | If less than one day: hrs. min.

9. Birthplace: Annapolis, Maryland (Town, county, and state)

10. Usual occupation: Waitress

11. Industry or business: Unknown

FATHER

12. Name: Charles Stevens

13. Birthplace: unknown

MOTHER

14. Maiden name: Belinda Butler

15. Birthplace: unknown

18. Informant: Wm. A. Ventimiglia, M. D.

Address: Henryton, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof 8/3/1940 (month) (day) (year)

Cemetery or crematory: Bund Hill

Location: Annapolis Md

18. Funeral director: Charles H. Alexander

Address: Annapolis Md

19. July 29 19 40 (Date rec'd by registrar) Albert R. Swanckhaus Registrar

Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 29, 1940 19 , at 11:00 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 14 19 40, to July 29 19 40, and that I last saw her alive on July 29, 19 40.

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	Nov. 1939
Due to: --	
Due to: --	
Other conditions: --	

(Include pregnancy within 3 months of death)

Major findings:

Of operations: --

Of autopsy: --

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: -- Date of: --

Where did injury occur? -- (City or town) -- (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: -- Injured at work? --

23. SIGNATURE: Wm. A. Ventimiglia M. D. M. D. or other

Address: Henryton, Maryland Date signed 7/29/40

VS A 15

RECEIVED
AUG 3 1940
BUREAU F. S.

07460

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-B)

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 mos, 2 days

Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch

How long in hospital or institution? 2 mos., 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Cecil

City or town: Port Deposit (If outside city or town limits, write RURAL and give nearest town)

Street No.: 21 Center Street (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: CALVIN COOLIDGE STEWART

3.(b) Social Security Number: None

4. Sex: Male

5. Color or race: Colored

6.(a) Single, married, widowed, or divorced: Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 5, 1924

8. AGE: Years 15 | Months 11 | Days 16 | If less than one day: hrs. min.

9. Birthplace: Port Deposit, Maryland (Town, county, and state)

10. Usual occupation: Scholar

11. Industry or business: Unknown

FATHER
12. Name: Joseph Stewart
13. Birthplace: Maryland

MOTHER
14. Maiden name: Margaret Johnson
15. Birthplace: Maryland

16. Informant: Wm. A. Venitmiglia, M. D.

Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 25 1940 (month) (day) (year)

Cemetery or crematory: Cokesbury

Location: Port Deposit Md.

18. Funeral director: Lee A. Patterson by M.L.P.

Address: Perryville Md.

19. July 21, 1940 (Date rec'd by registrar) Albert R Swankhouse Registrar

Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 21, 1940 19 at 12:15 A.M. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 19 1940, to July 21 1940 and that I last saw him alive on July 21 1940

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Jan. 1940
Due to --	
Due to --	
Other conditions --	

(Include pregnancy within 3 months of death)

Major findings of operations: -- Date of op.: --

Autopsy results: --

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: -- Date of: --

Where did injury occur? -- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): --

Means of injury: -- Injured at work? --

23. SIGNATURE: Wm. A. Venitmiglia M.D. M. D. or other

Address: Henryton, Maryland Date signed: 7/21/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
AUG 3 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07461

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch
Stay in hospital or inst. (yrs., or mos., or days): 21 days
Stay in this community (yrs., or mos., or days): Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Harford
City or town: Fallston Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: none

3. (a) FULL NAME: DOROTHY OLEDA STEWART

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6 (b) Name of husband or wife: Benjamin Stewart
Fallston, Maryland 6(c) If alive, give age: Unknown years

7. Birth date of deceased (mo., day, yr.): June 26, 1921

8. AGE:

Years	Months	Days	If less than one day
19	0	7	____ hrs. ____ min.

9. Birthplace: DArlington, Maryland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: unknown

FATHER
12. Name: David Haynes
13. Birthplace: Maryland

MOTHER
14. Maiden name: Molly Harris
15. Birthplace: Maryland

18. Informant: Dr. Reuben Hoffman
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 7 1940 (month) (day) (year)
Cemetery or crematory: Friendship
Location: near Fount Hill, Md
18. Funeral director: Dean & Foster
Address: Bel Air Md

19. 7/3/40 (Date rec'd by registrar) 19____ Albert R. Swanborn Registrar
Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 3, 1940 19____, at 8:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 12, 1940 19____, to July 3, 1940 19____, and that I last saw her alive on July 3, 1940 19____.

Immediate cause of death: Pulmonary Tuberculosis — DURATION: June 1939
Due to: --
Due to: --
Other conditions: --
(Include pregnancy within 3 months of death)
Major findings:
Of operations: --
Of autopsy: --

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: -- Date of: --
Where did injury occur? -- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: -- Injured at work? --

23. SIGNATURE: Reuben Hoffman, M.D. Superintendent M. D. or other
Address: Henryton, Maryland Date signed: 7/3/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
AUG 3 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

CERTIFICATE OF DEATH

07462

Reg. Dist. No. 75

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Carroll
City or town Rural near Linebaro
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 28 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Nr. Linboro Rural Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Elizabeth Stifflex

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	married

6 (b) Name of husband ~~or wife~~ Alpheus Stifflex
6(c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) November 15, 1868

8. AGE: Years 71 | Months 7 | Days 15 | If less than one day ____ hrs. ____ min.

9. Birthplace Carroll Co., Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Geo. Wagner
13. Birthplace Germany

MOTHER 14. Maiden name Eve Seiple
15. Birthplace Germany

16. Informant George E. Stiffler
Address Linboro Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 4 1940 (month) (day) (year)
Cemetery or crematory Pleasant View
Location Gen. Delivery Po
18. Funeral director G. W. Gerber & Son
Address Glen Rock, Pa

19. July 2 1940 Mrs. M. P. S. Denner
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1 1940, at 11:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 5 1940, to July 1 1940, and that I last saw her alive on July 1 1940.

Immediate cause of death	Cerebral Hemorrhage	
Due to	Arteriosclerosis	
Due to		
Other conditions		

DURATION

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. L. Yaglei M. D. or other
Address New Freedom Pa. Date signed July 2 - 40

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (58-C)

07463

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:

County Carroll

City or town Pleasant Valley
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 3 - 2 - 10

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Pleasant Valley Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Harold Goddard Stonesifer

3. (b) Social Security Number

4. Sex m

5. Color or race w

6. (a) Single, married, widowed, or divorced single

6 (b) Name of husband or wife —

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May. 19 - 1937

8. AGE: Years 3 Months 2 Days 10 If less than one day hrs. min.

9. Birthplace Pleasant Valley. Carroll Co. Md.
(Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER
12. Name William Stonesifer
13. Birthplace Carroll Co. Md.

MOTHER
14. Maiden name Ida Stonesifer
15. Birthplace Deep Run. Carroll Co. Md

16. Informant William Stonesifer

Address Westminster R. D. # 7

17. Burial Date thereof July 31. 1940
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory ~~Bachmans~~ Tyler's Cem.

Location Bachman Valley, Maryland.

18. Funeral director H Bankard & Son

Address Westminster, Maryland.

19. 7/30 19 40 [illegible]
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 28, 1940, at 6 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 10. 1940, to July 28 1940, and that I last saw him alive on July 27, 1940.

Immediate cause of death Endocarditis

Due to Rheumatism

Due to

Other conditions Influenza and pneumonia in April 1940
(Include pregnancy within 3 months of death)

Major findings:

Of operations —

Of autopsy

DURATION about 3 months

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE E Reese Wilkens
M. D. or other

Address Westminster Date signed July 30 1940

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
AUG 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07464

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch
Stay in hospital or inst. (yrs., or mos., or days): 2 days
Stay in this community (yrs., or mos., or days): Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 832 George St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: World War I

3. (a) FULL NAME: ALPHONSO THOMPSON

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6(b) Name of husband or wife: Unknown
6(c) If alive, give age: Unknown years

7. Birth date of deceased (mo., day, yr.): Sept. 13, 1892

8. AGE: Years: 47 Months: 10 Days: 6 If less than one day: ____ hrs. ____ min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: Porter

11. Industry or business: Unknown

FATHER
12. Name: Wilson Thompson
13. Birthplace: E West River, Md.

MOTHER
14. Maiden name: Mary Fountain
15. Birthplace: West River, Md.

16. Informant: Reuben Hoffman, M. D.
Address: Henryton, Maryland

17. Burial, cremation, or removal. Which?: Burial Date thereof: July 19 40 (month) (day) (year)

Cemetery or crematory: Mt Zion

Location:

18. Funeral director: Mrs. S. T. Hemsley
Address: 518 N. Biddle St.

19. 7/19/40 (Date rec'd by registrar) 19____ Albert R. Swankhouser Registrar
Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 19, 1940 19____, at 12:55 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 17 1940 to July 19 1940 and that I last saw him alive on July 19 1940

Immediate cause of death: Pulmonary Tuberculosis — DURATION: June 1937

Due to: --

Due to: --

Other conditions: --

(Include pregnancy within 3 months of death)

Major findings of operations: --

Major findings of autopsy: --

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: -- Date of: --

Where did injury occur? -- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): --

Means of injury: -- Injured at work? --

23. SIGNATURE: Reuben Hoffman M. D. M. D. or other

Address: Henryton, Maryland Date signed: 7/19/40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
AUG 3 1940
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07465

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch

Stay in hospital or inst. (yrs., or mos., or days): 10 days

Stay in this community (yrs., or mos., or days): Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Gaithersburg Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Marie Ellen Turner

3. (b) Social Security Number: 11-14-1074

4. Sex: Female

5. Color or race: Colored

6. (a) Single, married, widowed, or divorced: Separated

6 (b) Name of husband or wife: Richard Turner

6(c) If alive, give age: 55 years

7. Birth date of deceased (mo., day, yr.): December 27, 1900

8. AGE: Years: 39 Months: 7 Days: 2 If less than one day: hrs. min.

9. Birthplace: Washington, D. C. (Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business: Unknown

FATHER

12. Name: Richard Taylor

13. Birthplace: Richmond, Virginia

MOTHER

14. Maiden name: Mary Bridgett

15. Birthplace: Richmond, Virginia

16. Informant: Wm. A. Ventimiglia, M. D.

Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 30/40 (month) (day) (year)

Cemetery or crematory: Quoy Grove Md

Location: Near Gaithersburg Md

18. Funeral director: [illegible]

Address: Gaithersburg Md

19. July 29 1940 (Date rec'd by registrar) Albert R. Swankhaus Registrar

Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 29, 1940 19 2:30 A.M. at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 19 1940 to July 29 1940 and that I last saw her alive on July 29 1940

Immediate cause of death: Pulmonary Tuberculosis — DURATION: Dec. 1939

Due to: --

Due to: --

Other conditions: --

(Include pregnancy within 3 months of death)

Major findings:

Of operations: --

Of autopsy: --

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: -- Date of: --

Where did injury occur? -- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): --

Means of injury: -- Injured at work? --

23. SIGNATURE: Wm. A. Ventimiglia M.D. M. D. or other

Address: Henryton, Maryland Date signed: 7/29/40

RECEIVED
AUG 3 1940
BUREAU V. S.

07466

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-E)

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:

County: Carroll

City or town: Westminster

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 300 Green St.

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: ~~Carroll~~ Frederick

City or town: ~~Westminster~~ Frederick, Md Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: ~~300 Green Street~~ 24 Bentz St.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: None

3. (a) FULL NAME: Mrs. Maude Whiting

3. (b) Social Security Number: None

4. Sex: Female

5. Color or race: Colored

6. (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Harley Whiting

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov 15 - 1886

8. AGE: Years: 53 Months: 8 Days: 2 If less than one day: hrs. min.

9. Birthplace: Frederick Co. Md. (Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business: At Home

FATHER

12. Name: George Lyles

13. Birthplace: Frederick Co. Md.

MOTHER

14. Maiden name: Charlotte Carpenter

15. Birthplace: Frederick Co. Md.

16. Informant: Mrs. Kermit Smallwood

Address: ~~300 Green St., Westminster, Md~~ Frederick, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 7/20/1940 (month) (day) (year)

Cemetery or crematory: Fairview

Location: Frederick, Md.

18. Funeral director: M. R. Etchison & Son

Address: Frederick, Md.

19. 7/17 1940 [signature] (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 17th 1940, at 3 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 14th 1940, to July 17th 1940, and that I last saw her alive on July 14th 1940.

Immediate cause of death: Uremic Coma — DURATION: 2 day

Due to: Chronic Parenchymatous nephritis

Due to: ( ) 1 yr

Other conditions: Had been in Frederick Hospital

(Include pregnancy within 3 months of death)

Major findings:

Dt operations:

Dt autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: J. L. Billingsley M. D. or other

Address: Westminster Md. Date signed: 7/17/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
AUG 5 1940
BUREAU V. S.

STATE OF MARYLAND—CERTIFICATE OF DEATH

07467

1. PLACE OF DEATH 83a

County Carroll Registration Dist. No. 77

Village or City Hampstead No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 3 yrs. 6 mos. 6 ds. How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Howard E. Wilhelm

(a) Residence: No. St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Male	White	married

5a. If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Alice Wilhelm

6. DATE OF BIRTH (month, day, and year) May 21, 1874

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
66	1	16	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Farmer

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. Retired

10. Date deceased last worked at this occupation (month and year) 1937

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Pennsylvania

FATHER

13. NAME Elpander Wilhelm

14. BIRTHPLACE (city or town) (State or country) Pennsylvania

MOTHER

15. MAIDEN NAME Mary Bunsth

16. BIRTHPLACE (city or town) (State or country) Maryland

17. INFORMANT (Address) Mrs. Alice Wilhelm Hampstead Md

18. BURIAL, CREMATION, OR REMOVAL Place Greenmount Mem Date 7-10, 1940

19. UNDERTAKER Jacob Winkler Sons (Address) Manchester Md

20. FILED July 8, 1940 Mildred S. Hughes Deputy Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH July (Month) 7 (Day), 1940 (Year)

22. I HEREBY CERTIFY, That I attended deceased from July 1, 1940, to July 7, 1940

Last saw him alive on July 7, 1940; death is said to have occurred on the date stated above, at 8:05 p.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
(1) Arterio-sclerosis with Hypertension	1936
(2) Cerebral Hemmorrhage	7-3-40
Other Contributory Causes of Importance:	

Name of operation Date of

What test confirmed diagnosis? Clinical Was there an autopsy? No

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, In HOME, or in PUBLIC PLACE.

Manner of injury

Nature of Injury

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) Maurice C. Porter, Jr. M. D.

(Address) Hampstead, Md

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as **at school** or **at home**. For a woman whose only occupation was that of home housework, write **housewife** in answer to Question 8 and **own home** in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel**, etc. For a person who had no occupation whatever write **none**.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver**, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill**, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer**, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist**, etc. Distinguish carefully between **retail merchants** and **wholesale merchants**. A person who sells goods should be called a **salesman** and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

RECEIVED
AUG 1940
BUREAU V. S.

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

07468

CERTIFICATE OF DEATH

Reg. Dist. No. 77

1. PLACE OF DEATH:

County Carroll

City or town Rural near Hampstead

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 2 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Rural near Hampstead Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR ✓

3. (a) FULL NAME William C. Wilhide

3. (b) Social Security Number ✓

4. Sex Male

5. Color or race white

6. (a) Single, married, widowed, or divorced widower

6 (b) Name of husband or wife Amanda V Wilhide

✓ 6(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) September 9-1868

8. AGE: Years 71 Months 10 Days 14 If less than one day ___ hrs. ___ min.

9. Birthplace Thurmont, Frederick Co Md

(Town, county, and state)

10. Usual occupation None

11. Industry or business ✓

FATHER 12. Name Unknown

13. Birthplace "

MOTHER 14. Maiden name Unknown

15. Birthplace "

16. Informant Mrs J Harry Blocher

Address Hampstead Md

17. Burial Date thereof July 24/40

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St Pauls

Location Arcadia Md

18. Funeral director Edw C Tipton

Address Hampstead Md

19. July 23 1940 John S. Hughes, Jr.

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 23 1940, at 1A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr 1 1936 to July 23 1940, and that I last saw him alive on July 19 1940.

Immediate cause of death Coronary Sclerosis

Due to Chr. Myocarditis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION 1 yr.

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE William R S Denner M. D. or other

Address Manchester Md Date signed 7/23/40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
AUG 2 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07469

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 dys
Hospital, Institution, or street address where death occurred:
Springfield State Hosp.
How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto., City
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1912 Eastern Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: John W. Witten

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mary Witten
6.(c) If alive, give age: 67 years

7. Birth date of deceased (mo., day, yr.): July 20, 1859

8. AGE: Years	Months	Days	If less than one day
81	0	2	....hrs. ....min.

9. Birthplace: unknown
(Town, county, and state)

10. Usual occupation: Saloon Keeper

11. Industry or business:

FATHER
12. Name: John Witten
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Records S.S.H.
Address: Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 23/40 (month) (day) (year)
Cemetery or crematory: Schwandt Bros
Location: Donnell Rd
18. Funeral director: Tilley & Zwiesler Inc
Address: 4036 Wolfe St
19. July 22 1940 (Date rec'd by registrar) C. Harry Hess Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 22 1940 at 5:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 19 1940 to July 22 1940 and that I last saw him alive on July 22 1940

Immediate cause of death	DURATION
Chronic Myocarditis	Prior
Generalized Arteriosclerosis	To Adm.
Due to:	
Due to:	
Other conditions: Senility	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Alan Faccleer M.D.
M. D. or other
Address: Springfield State Hosp. Date signed: 7/22/40

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
AUG 3 1940

07470

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-6)

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 mo.

Hospital, Institution, or street address where death occurred: Springfield State Hosp.

How long in hospital or institution? 3 mo.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Frederick

City or town: Frederick (If outside city or town limits, write RURAL and give nearest town)

Street No. 17 E. 2nd St. (If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: Alban Morley Wood

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	M

6.(b) Name of ~~husband~~ or wife: Mrs. (Alban) Louise Wood

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 10, 1885

8. AGE:

Years	Months	Days	If less than one day
55	1	17	..... hrs. ..... min.

9. Birthplace: Frederick, Md. (Town, county, and state)

10. Usual occupation: Attorney

11. Industry or business:

FATHER
12. Name: John Eldridge Wood
13. Birthplace: Frederick, Md.

MOTHER
14. Maiden name: Anna O. Shreve
15. Birthplace: Virginia

16. Informant: Wife

Address: Frederick

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 7/29/40 (month) (day) (year)

Cemetery or crematory: Mt. Olivet

Location: Frederick

18. Funeral director: Harry E. Carty Co.

Address: Frederick

19. July 27 1940 (Date rec'd by registrar) C. Harvey Weer, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 27 1940 at 5 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4/19/40 19..., to 7/27/40 19..., and that I last saw him alive on 7/27/40 19...

Immediate cause of death	DURATION
Hemiplegia	
Cerebral thrombosis. Duration: Unknown. CWGR	
Due to Arteriosclerosis + hypertension	8 yrs.
Due to Generalized arteriosclerosis.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: Jerome Hartz, M.D. (M. D. or other)

Address: Springfield State Hosp. Date signed: 7/27/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
AUG 3 1940
U. S.